A GUIDE FOR PLANNING WITHDRAWAL MANAGEMENT SERVICES

in

Rural and Remote Areas

and Small Urban Centres

of Ontario

ARF Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

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HOW TO USE THIS GUIDE

The Executive Summary provides a quick overview of the planning guide. Planners may find it useful when contacting important people in their community who might join a planning group. The summary can help to generate interest in and commitment to your project.

The Guide for Planning is an information resource. You may move through the chapters one by one, or select those chapters that are most helpful to the stage your group has reached in planning.

This guide has a number of features to encourage discussion and information exchange including: the questions and the examples from Timiskaming at the end of each chapter; the bibliography (Appendix 4); the list of key contacts in withdrawal management (Appendix 5); and, finally, the binder format of the document, which can be easily updated with new information.

We hope that your group will share your experience in planning withdrawal management services by adding examples from your community to this guide. Should you wish to participate in this updating process, please contact Dennis Bernardi or Anastasia Bush (addresses and telephone numbers are listed in Appendix 5.)

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INTRODUCTION TO THIS GUIDE

PURPOSE AND STRUCTURE

In this planning guide, we discuss how to plan *withdrawal management services* – services that help people while their bodies get rid of alcohol and other drugs and adapt to a drug-free state. The guide is for community groups who either wish to establish a service in a small urban centre, rural or remote area, or to improve an existing urban service. It encourages these groups to explore different options for service delivery, to discuss key issues in withdrawal management, and to develop comprehensive and cost-effective service plans.

The guide begins with background information to introduce the key issues of withdrawal management and review Ontario's approach, which favors the social setting detox centre. Next, we discuss some preliminary considerations and explain our framework for planning withdrawal management services. The framework's four components are Service Awareness, Assessment, Managing Withdrawal, and Planning for Continuing Treatment. Each component is illustrated with examples from the research literature and incorporates considerations for Ontario's rural and remote areas and small urban centres. The guide closes by briefly considering the final planning steps: evaluation and proposal writing.

To help community groups make practical use of the information in this guide, we summarize each chapter in a series of questions that groups can use as they address different aspects of planning. By using these questions as a starting point for discussion, your planning group can explore the various alternatives and develop a comprehensive service plan.

After the summary questions in each chapter, the guide offers the experience of one local planning group, the Timiskaming Detoxification Planning Committee. The Timiskaming planners have worked since 1991 to create withdrawal management services in their community. They volunteered to test our planning framework.

When they were approached by our committee, they had already completed a needs assessment, had formed a group of community representatives and were beginning to plan a withdrawal management service. The collaboration benefitted us both. The experience of Timiskaming planners provides your group with one example of how our framework can be developed for a specific community. This section can be updated as groups like yours work through the planning process.

UNDERLYING PRINCIPLES

We adopted three principles to shape the planning framework.

Withdrawal management services are a vital part of the addiction treatment system and are currently needed by the majority of planning districts in Ontario.

Principle One: The Increasing Role of Withdrawal Management Services

Withdrawal management services are a vital part of the addiction treatment system, and most planning districts in Ontario need them. In addition to managing withdrawal, they can play an increasing role in Ontario's treatment system by raising community awareness, providing withdrawal management assessments and planning for continuing treatment.

They can play an increasing role in Ontario's treatment system by adding service awareness, withdrawal management assessment, and planning for continuing treatment activities to service plans.

In offering this planning guide, we join with those who have identified a need for more withdrawal management services in Ontario. Since 1984, addictions professionals have been pointing out that many small urban centres and rural and remote areas do not have withdrawal management services.[1] One Ontario planning district, Sudbury-Manitoulin, has worked since 1987 to obtain funds for delivering detoxification services, without success.[2] This is not an isolated experience; the York Region planning group submitted its first proposal in 1988 and is still trying to get support for detoxification services.[3] A recent Addiction Research Foundation report[4] indicates that 61 per cent of Ontario's planning districts have identified a need for detox beds, detox services for women, drug users and youth, medical supervision during detox, and/or better access to detox services. These needs were also identified in *Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's*, which recommended "the expansion of detoxification services with priority given to approaches more suited to small urban centres, rural and remote areas."[5]

The planning framework we propose supports community efforts to expand services for managing withdrawal. The framework includes two components that are not always linked with Ontario's detox centres: first, a marketing component to raise awareness of and promote access to the service; and, second, an assessment component to help staff select the most suitable withdrawal management service for an individual. The framework also includes components that are traditionally linked with detoxification – managing withdrawal and planning for continuing treatment.

Principle Two: The Role of the Social Setting Detox Centre

This planning guide emphasizes that the social setting detox centre is only one among several possible ways to deliver withdrawal management services. Planning groups need to consider a variety of methods, especially in Ontario's small urban centres and rural and remote areas.

Since first piloted and tested in 1968, the social setting detox centre has become the standard method for delivering detoxification services in Ontario. However, Ontario's 29 detox centres were designed for (and are mostly found in) larger urban settings. Therefore, we began our work with the idea that the detox centre may not be appropriate in other settings and should not be considered the standard way to provide assistance in all areas of the province. Instead, we took the urban model as a starting point for exploring other methods.

Although the social setting detox centre has become the standard method of delivering detoxification services to Ontario citizens, it was designed for an urban setting.

Indeed, allowing the detox centre model to set the standards for delivering these services in Ontario has hampered efforts to develop other methods.[6] Withdrawal management in Ontario is almost always associated with the detox centre and the population it was designed to serve. Unfortunately, this association has not only narrowed the definition of people who need help to withdraw from alcohol and other drugs, but it has limited the view of how to help these people. For example, there have been no previous attempts to define a target population who cannot or will not go to detox centres. Nor has there been any attempt to enlarge the objectives for withdrawal management services to encourage the development of new methods and settings. Our planning framework therefore expands both the definition of people needing help and the objectives for delivering withdrawal management services.

The urban model has drawn attention away from exploring alternative services that might be more suitable for non-urban areas of the province.

Despite the view that detox centres are the standard approach to detoxification in Ontario, other methods are already in use. For example, in 1993, the Drug and Alcohol Registry of Treatment (DART) listed 33 agencies that provided detoxification services. Twenty-nine of these agencies were the social setting detox centres of Ontario, which offered exclusively non-medical detoxification. (As detox centres do not employ doctors or nurses, they do not provide clients with medical care during withdrawal.) However, one of the agencies offered only medically managed detoxification, and three agencies provided both medical and non-medical detoxification. Acute care and psychiatric hospitals also help people during withdrawal, although addiction problems are not their primary function. A network of volunteers, agencies, self-help or support groups, group homes and hostels also offers assistance during withdrawal. These alternative methods complement Ontario's formal and funded addiction service system and play a significant role by helping communities without detox centres. In our planning framework we have considered these alternative options for helping people withdraw from drugs and alcohol.

Settings other than detox centres are used to provide detoxification services in non-urban Ontario, and these alternatives should be considered by service planners.

Principle Three: The Role of Planning Groups

The planning guide supports the efforts of community planning groups. We believe that people in the community can best develop the range of effective services that will respond to the needs of their community and will reduce costs (both human and financial) over the long term.

Service plans are best developed by community planning groups.

Our framework incorporates the Ontario Ministry of Health's perspective, which prefers that the community (rather than the government) manage the planning, implementation and evaluation of their services. For example, the 1993 Substance Abuse Strategy of Ontario supports community-planned alternatives to residential care.[7] The underlying principle is that people in a community produce service plans that use the resources available and address the community's needs.

Community planning will ensure that services will respond to community needs and the needs of individual clients.

Because needs and resources differ substantially from one area to another, no single method of delivering withdrawal management services is suitable for every Ontario community. In fact, no single method will be suitable for every individual. Therefore, we base our framework on the idea that people can be matched to a range of services that respond to their individual needs and resources in a positive way.

An emphasis on pro-active service delivery measures will result in sound and cost-effective service plans.

Keeping costs down is, of course, a major concern. Accordingly, we promote the planning of better services that are less expensive in the long run. For example, the guide recommends training professionals and volunteers in standard techniques, enlisting the client's support persons and delivering less intrusive services to people with fewer problems. *A Vision for the 90's* recommends ways in which community professionals in health and social services can work with specialized addictions services to help people with alcohol and other drug problems.[8] We have incorporated this vision into our guide.

In summary, we propose a planning framework that supports the vital role played by withdrawal management services in the treatment of alcohol and drug problems. The framework builds upon the strengths of the social setting detox centres and will help community planners to avoid their limitations in non-urban settings. Using the framework, community groups will plan responsive and effective services, putting Ontario's Substance Abuse Strategy into action by developing "more innovative ways to deliver effective services, especially to those with special needs."[9]

THE SOCIAL SETTING DETOX CENTRE

Ontario's detox centres serve many people who need help to manage withdrawal.

At the close of the 1992-93 fiscal year, Ontario's detox centres had accepted 43,426 admissions, including repeat admissions. (Statistics for March 1993 are included in Appendix 1.) We believe that detox centres provide most of Ontario's detoxification services. However, there are no provincial records to support this

belief. In Ontario, there is no listing of the number of people receiving assistance in other settings, such as the home, jail or hospital.

The detox centre is like an emergency room for the addiction treatment system, providing crisis intervention, continuous monitoring, stabilization, assessment and referral. In addition, both detox centres and hospital emergency rooms can lead to specialized treatment. The emergency room model for detox centres requires 24-hour availability in a building staffed by two trained professionals at all times. In this model, the detox centre[10] is a "crisis care unit," intervening immediately with people who are intoxicated or in withdrawal. It offers supportive care in a social (non-medical) setting[11] that addresses a client's basic physical and psychosocial needs. Detox centre staff, who help create this supportive environment, include addiction specialists, people in recovery and volunteers. Their training consists of non-violent crisis intervention techniques, first aid, assessment methods and basic counselling. The unique contribution of the detox centre is that it opens a door[12] to the addiction treatment system, referring clients to continuing treatment once their physical health has been somewhat restored.

The hospital emergency room provided the model for the detox centre, dictating some of the standards for service delivery.

Service Objectives

The objectives for Ontario's social setting detox centres have evolved in response to a variety of influences. Originally, detox centres were set up to help public inebriates who would otherwise experience withdrawal in jail, where they would not receive the support or assistance necessary to link them with continuing treatment.[13] In 1976, an Addiction Research Foundation Task Force evaluated the impact that detox centres were having on their clients, finding that they "do not appear to have played a significant role in changing the lifestyles of most men on skid row."[14] This report also documented changes in the population being served by detox centres, and suggested a return to the original objectives of the detox centre.

Originally, the social setting detox centres were to provide the "chronic drunkenness offender" with a non-judgmental and safe alternative to jail.

In 1979, the Ontario Ministry of Health issued its *Guidelines for the Planning, Organization and Operation of a Detoxification Unit.* The *Guidelines* state: "It is felt that the ready availability of detoxification services offers cost effective care with the possibility of referral at a later date to rehabilitative services." This document introduced the idea that detox centres should save the province money by providing a service that costs less than hospital or jail for people needing help during withdrawal.

Subsequently, it was determined that detox centres were cost-effective in large urban centres.

Since then, each detox centre has set its own objectives. When The Phillips Group of Companies conducted an operational review of detox centres for the Ministry of Health, it examined these objectives. In 1990, the *Report on the Operational Review of [the] Ontario Detoxication Program* concluded that service objectives varied from detox centre to detox centre, and that they did not correspond to the original objectives. The report called for the Community Mental Health Branch of the Ontario Ministry of Health to review the objectives for detoxification services.

Recently, each detox centre has set its own objectives, and these can differ from centre to centre.

In 1992, detox centre objectives were reviewed by the Community Mental Health Branch of the Ontario Ministry of Health, resulting in an expanded mandate.

In response, the Community Mental Health Branch provided a new mandate for detox centres. The new mandate recognized that detox centres also help people who: (1) are dependent on drugs other than alcohol; (2) are not "chronic drunkenness offenders"; and, (3) suffer from a multitude of practical stresses, such as housing and employment, and may have other concerns besides addiction, such as physical and psychiatric disorders. The Community Mental Health Branch's 1992 *Ontario Detoxification Program Service Implementation Plan* states, in part:

> The primary role of the Centre is to assist an individual in managing withdrawal in a safe, caring, non-threatening and empathetic environment. The Centre strives to enable the person to take responsibility for his/her life through respect, independence, dignity and confidentiality. Staff of the Centre will facilitate individualized post detox treatment/care.
>
> The non-medical detoxification centre is a crisis service or, the entry point for a certain segment of the population where the person begins the rehabilitation process related to addiction/chemical dependency, including alcohol and other psycho-active drugs.

This implementation plan emphasizes that detox centres must act as a first step in a continuum of care that promotes recovery from alcohol and drug problems.

In Ontario, there has been no effort to develop a general structure for planning and delivering withdrawal management services. In such a structure, detox centres as well as other methods and settings for service delivery would all have a role in providing withdrawal management services. We offer such a structure in this planning guide.

Target Population

The detox centre target population has also been evolving and has been the subject of review in studies and government reports.

The defined target population for detox centres has also been evolving. Originally, detox centres were expected to serve the "chronic drunkenness offender." However, the client population has changed. A variety of reports and studies have shown that drug use, with or without the use of alcohol, is common among detox centre clients.[15] In Ontario, 32 per cent of people admitted to Hamilton-Wentworth detox centres during 1992-93 reported problems related to drugs other than alcohol.[16] Studies also show that detox centres provide service to people at their own request (that is, not all people were being brought in by police) and that a significant portion of clients are more socially stable, with homes or employment, than the original target population.[17]

We can describe the clients of detox centres by referring to the monthly data about admissions and discharges that detox centres collect for the Ontario Ministry of Health. These statistics record the age, gender and referral source of clients. For example, of the 1992-93 admissions, 14 per cent were female clients, which is less than the proportion of women in addiction treatment programs overall by about 8 per cent.[18] Although detox centres serve people 16 years and over, the average client age was 34 years in January 1993 and 38 years in March 1993.

Statistics collected by detox centres for the Ministry of Health characterize the population being served by gender, age and referral source.

Detox centre statistics for referral source tell us more about who is using detox centres. Of the 3,691 clients admitted in March of 1993, the sources of referral were the following: self (n=1,986), police (n=556), hospital (n=341), other agency (n=289), family/friend or Alcoholics/Narcotics Anonymous (n=289), rehabilitation facility (n=160), physician (n=39), assessment/referral centre (n=35). These statistics reveal, first, that some detox centre clients are approaching the medical establishment for help (many were referred by hospitals and physicians). Also, most clients either determined on their own to seek help or were identified by friends, family or self-help/support groups as requiring assistance to withdraw from alcohol and other drugs. By contrast, the number of clients referred by police represents a smaller portion.

In response to the available evidence and motivated by the *Operational Review*, the Community Mental Health Branch of the Ontario Ministry of Health developed an expanded Admission Policy for detox centres as part of their *Service Implementation Plan (Appendix E)*: "Males, females 16+; Intoxicated, withdrawing from, (or in crisis) about alcohol and/or other drugs; Intoxication/withdrawal from substances that can be safely managed in a non-medical setting." This admission policy requires detox centres to meet the needs of people who are withdrawing from substances other than alcohol, and to accommodate all people, in accordance with the Human Rights Code, by responding to a wide spectrum of needs and resources.

The Community Mental Health Branch of the Ontario Ministry of Health defined an expanded target population for detox centres, which now includes drug users.

This mandate has expanded the target population of the detox centre. This expansion has implications for both training and research that we are only beginning to address in Ontario. For example, there is a need for research and training about how to "safely manage" withdrawal from drugs and substances other than alcohol in a social setting. As well, detox centres routinely help people who have concurrent psychiatric or medical conditions, such as HIV/AIDS. The needs of these clients are sometimes beyond the training of staff members, but in urban communities they can be managed in the emergency medical centres close by. In a small urban centre, rural or remote area, these complications create distressing challenges for non-medical staff who are responsible for client safety. Helping people who need more than the average resources during withdrawal should be a primary concern at every level of service planning, delivery and evaluation.

There is a need for detailed data about Ontario's detox centre clients.

In addition to these problems, the available definitions of the target population are not specific enough. Community planners need precise data about detox centre clients to help them define target groups. Some detox centres record detailed information about their clients, but they are not required by the Ministry of Health to record the substance or combinations of substance used by their clients, or their clients' social stability, disabilities, cultural backgrounds, and severity of dependence. This information would help planners in three ways: first, to define the target population for withdrawal management services; second, to develop standard assessment techniques for those services; and third, to recommend appropriate settings and methods for individual clients.

There is a need to account for those who are not using detox centres and may be receiving assistance from other sources.

Furthermore, the definitions do not account for people who are not receiving help, or for people receiving help outside a detox centre. On the one hand, the urban model has provided a safe service to the original target population and other people at a lower cost than jails and hospitals. On the other hand, people without access to a detox centre, such as those in rural and remote communities, young people under the age of 16, and women who are caring for dependants, are either receiving help from other sources or not receiving help at all.[19] For these people, the 1990 *Operational Review* recommended that the Community Mental Health Branch "explore through pilots the merits of alternate models to 'bricks and mortar' for detoxifying people."[20] In other words, the detox centre is simply not the answer for some people and these people need to be included as part of the target population for services.

Exploring alternative ways of delivering service requires that planners define the target population and ensure that these people have access to the service.

In Ontario, there has been no attempt to define who needs assistance during withdrawal apart from answering the question, *Who needs a detox centre?* One possible reason for this oversight seems to be the very nature of the urban model. Open 24 hours a day in a large urban setting, detox centres serve a variety of people in addition to the original target group. They have been able to expand their range of clients without defining an expanded target population, and without any special effort to encourage use. When planners are exploring alternative ways to help clients that would be suitable for rural and remote areas and small urban centres, they must address these issues. In this planning guide, we offer a working definition of the target population that local planning groups can tailor to their communities.

S U M M A R Y

For over a decade, the social setting detox centre has set the standards for care during withdrawal. Detox centres have limitations for delivering service in Ontario's smaller communities. In your planning group, ask the following questions to begin discussing the information in Chapter 1 and applying it to your service plan. Timiskaming's plans are one example to guide you.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. Do detox centres currently play a role in our community's continuum of care for alcohol and drug problems? If so, what is that role?

2. What are some of the other ways that people obtain assistance during withdrawal in our community?

3. What are our priorities for increasing the role of withdrawal management? For example, how can we remove barriers, or expand or improve services?

4. What do we need to learn from the experience of other Ontario communities?

EXAMPLES FROM TIMISKAMING

Currently, there is no service in the district dedicated to providing detoxification. Referrals to distant detox centres are minimal and there is a high rate of inappropriate referral. In Timiskaming, the service will help clients, mobilize the community around the planning, implementation and delivery of withdrawal management services, and provide outreach to underserviced populations.

CHAPTER 2
GETTING STARTED

Developing withdrawal management services to meet local needs requires a planning context. We begin by discussing the first two steps – creating community links and identifying community needs and resources. Your local District Health Council can provide you with expert consultation and assistance in taking these steps; there may be small amounts of funding available to help you get started. Ontario's District Health Councils are listed in Appendix 5.

CREATING LINKS IN THE COMMUNITY

This guide presents a framework for planning withdrawal management services. But people planning a service for a specific Ontario community need to create links among resources and ensure the commitment of the community. To accomplish these tasks, it is best to establish a co-ordinating group of professionals, volunteers and consumers at the early planning stages (if your community does not already have such a group). This approach is supported by Ontario's Substance Abuse Strategy, *Partners in Action.*

The development of this framework will require a local planning group of professionals, volunteers and consumers. Some of them will represent local referral sources for withdrawal management.

The World Health Organization also recommends this kind of group (a Community Action Team) and provides practical advice in its book, *Responding to drug and alcohol problems in the community.*[21] One of the first steps to take when forming an action team or planning group is to identify a wide assortment of referral sources. If possible, people from these referral sources should play a role in a local group. The group's membership may evolve during the three phases of service development – planning, promotion and implementation.

A group with diverse membership has three practical benefits. First, it will increase the number of appropriate referrals to your service. Many people who need help for substance abuse problems do not ask for assistance directly from addiction

Establishing a local network in the form of a planning group will increase appropriate referrals to withdrawal management.

services. As the American Institute of Medicine reports, people most often turn to non-addiction services for problems related or unrelated to their consumption of alcohol.[22] Addiction Research Foundation scientist Brian Rush estimates that 85 per cent of people in need will seek assistance elsewhere: private medical practices, community health centres, self-help programs, and so on.[23] A planning group that includes people from referral sources can create a better understanding of withdrawal management in the community, and attract a larger number of appropriate referrals from helping professionals and services.

The planning group will become a network that links caregivers in the community, thereby reducing the cost of delivering care.

The second benefit of developing a diverse planning group is that your group can become a local network for providing service. Existing resources can be less costly than new resources, and they may be equally effective, with appropriate procedures, policies and ongoing training. For example, not every community will be able to support specialized addiction staff responding 24 hours a day to referrals for withdrawal assessment. However, a local planning group can develop a comprehensive network that includes general practitioners, emergency room staff, social workers, spiritual leaders, police officers, volunteers and others. Using professional staff who are already "on the ground" in public health and social service can both reduce start-up costs and strengthen the network. Planning groups with diverse membership will ensure that their policies and procedures address the needs of the care-giving community. They will also improve on the quality and consistency of the care already provided by this community to people needing assistance during withdrawal.

Including local addiction treatment professionals in the planning group will create a systematic approach to delivering a continuum of addiction services in the community.

Finally, a planning group that includes members from addiction treatment services offers a third benefit – a two-way flow of clients. Addiction treatment agencies create candidates for withdrawal management services by requiring that their clients be substance-free before entering treatment. (In fact, this was required by all but five of the addictions services that were registered with DART in 1993 and that provided short- or long-term treatment, family intervention, outpatient and day or evening treatment.) Withdrawal management services create clients for the rest of the addiction treatment system by helping clients plan for continuing treatment.

Indeed, local addiction planning groups foster opportunities for more responsive and cost-effective client services for each stage of recovery. The city of Owen Sound provides an example. When its detox centre was being planned, four beds were allocated to clients attending the local day treatment program at Grey-Bruce Regional Health Centre. Later, planners expanded this concept to include detox centre clients who were waiting for continuing treatment elsewhere in the province. By using a systems approach and forming a Joint Community Addictions Advisory Board which included membership from the detox centre, G & B House recovery home, the assessment/referral centre and the day treatment program at Grey-Bruce Regional Health Centre, all members were able to co-ordinate their activities and make the best use of a variety of services.

DEFINING NEED AND IDENTIFYING RESOURCES

When defining the service's target population, planning groups must identify how many people are and will be in need of withdrawal management services. This is a complex process that involves the following steps:

- collecting information about current service use
- accounting for people who need the service but are not using it
- anticipating increases or decreases in both these areas over time.

There is no easy way to accomplish these tasks. Some organizations, such as the Ontario Ministry of Health, offer planners formulas that are based on population, and seem attractively simple. However, defining need by formula can be hazardous in small urban, rural and remote areas, where the population is scattered across a large region. These formulas could tempt you to increase the geographical area for your service in order to make sure you have many clients. But when the area is extended, access becomes difficult and your service must offer transportation. We recommend that you use population-based formulas only as a general guide.

In the past, the Ontario Ministry of Health has offered three such formulas. The first two will not be useful for planners.[24] The third and most recent one, however, has been used by several planning districts to define the target population in their area, so we will consider it more closely. ARF scientist Brian Rush developed this formula for the Ministry of Health's *A Framework for the Response to Alcohol and Drug Problems in Ontario*. Although it is population-based and restricted to alcohol problems, this tool can help planners estimate the need for different types of addiction service.

The formula of ARF scientist Brian Rush is a guide which can be adjusted to reflect community realities and the service being planned.

According to the formula, all those drinking 35 drinks or more per week are in need of specialized treatment. Of these people needing specialized treatment, only 15 per cent will seek it during any given year. And of those people seeking treatment, 40 per cent will require detoxification. Therefore, Rush estimates that in any given year, about six per cent of those in the general population who are drinking 35 drinks a week or more will need withdrawal management. For example, in a hypothetical population of 10,000 people in need of specialized treatment, about 1,500 people will seek it and about 600 will require detoxification.

CALCULATION ON A HYPOTHETICAL POPULATION		
Pop'n in need of treatment (drinking 35+ drinks per week)	100%	10,000
Pop'n seeking treatment	15%	1,500
Pop'n needing withdrawal management (40% of those seeking treatment)	6%	600

We encourage you to adjust the formula to fit your community and the service you are planning. The formula is based on a definition of need that may not correspond with the need in your area. People drinking 35 drinks or more per week certainly require specialized service, but they are not the only ones. Planners will also want

Planners can also assess the needs of people who are not covered by Rush's formula.

to serve people who are using illegal drugs, misusing prescription drugs, or using inhalants or solvents to get high; people who are less than 15 years of age; and people who are not using alcohol at high-risk levels, but who are experiencing problems because of alcohol use.

If an increase in demand is expected, it should be included in the needs assessment.

The formula rests on a fixed percentage of demand for specialized treatment. You may need to adjust the percentage upwards when you are planning access or outreach mechanisms and a campaign to make the community aware of the service. Keep in mind that any increase in the proportion of people seeking specialized treatment may also increase the percentage of people requiring help to manage withdrawal. For example, if 20 per cent of the people who need treatment seek it from addiction services (rather than the formula's 15 per cent), eight per cent of the population drinking 35 drinks or more per week will require assistance during withdrawal (rather than the formula's six per cent).

Needs assessments can be adjusted to accommodate early intervention strategies.

To identify what portion of the people who require addiction treatment should also receive withdrawal management services, planners need to consider who they are serving and what services they are offering. For example, Rush's calculation (that 40 per cent of the people who seek specialized treatment need detox) is based on a definition of people who receive assistance from detox centres and hospitals and are likely to be severely dependent on alcohol. When planners are developing a range of withdrawal management services to accommodate moderately dependent people, they should increase the percentage of people who need help to manage withdrawal.

Planning groups are encouraged to use the Addiction Research Foundation as a resource when identifying need in their community.

When identifying need, community planners can receive practical assistance from the Addiction Research Foundation. An ARF publication on this subject is available. As mentioned earlier, *Analysis of Addiction Treatment Needs Assessments Published by District Health Councils Between 1989 and 1992* is a review of the needs assessments conducted throughout Ontario. One of the authors of the report, John Zarebski, a Program Director at the ARF, believes that the single most common difficulty in assessing needs is identifying unmet needs.

Account for multi-stressed populations and future needs in your assessment.

Zarebski offers two suggestions for addressing this difficulty. First, he recommends that you identify the resource requirements of possible clients with special needs. For example, clients with a psychiatric disorder or clients who use both drugs and alcohol will require more resources. These groups of people should be weighted according to the resources they need. To do this, planners must know the cost of different service activities (such as client monitoring, assessment and administration). Acute care hospital administrators could help you with this task since they have been looking at their service in this way for several years. Zarebski's second suggestion is that you develop two tables, one showing the situation today and the other showing the situation at a point in the future, such as five or 10 years from now. The second table will include your predictions for the impact of population growth, the impact of the service in reducing drug and alcohol problems, and as many other variables as possible. Businesses are familiar with these kinds of projections and could help you create these tables.

The ARF can also help you to assess the need in your community by providing you with provincial statistics.[25] These statistics can give you the quantitative data for your assessment. In addition to numbers, people in your community can help assess need by telling you about their experience with people needing help to manage withdrawal. You can obtain this kind of qualitative information through a formal survey or by a less formal interview. The procedure used by Timiskaming planners is an example of how needs assessments are commonly conducted, using both quantitative and qualitative indicators.[26] The study demonstrated that the community would benefit from having local withdrawal management services, and recommended the development of a service plan.

Use both quantitative and qualitative data in your needs assessment.

Once needs are identified, quantified and projected, planners must consider what services (inside and outside the community) are currently addressing these needs, including health care settings, addiction treatment settings and the self-help or volunteer network. You can also include community services that *could* address the need. For example, Timiskaming planners identified community and general hospitals and addiction treatment resources in the district, and listed these groups in a report entitled "Profile of Timiskaming Services." This kind of report can facilitate the planning process and also become a local service directory.

When identifying community resources, planners will include addiction services, residential health facilities, health care and social service agencies and the volunteer network.

S U M M A R Y

Ask the following questions to start a discussion about who should be in your planning group and how the needs of your community should be assessed. Timiskaming's work in this area will provide an example.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. Which people in our community do we need to involve in order to achieve our objectives?

2. What role could each of these people play in our planning group?

3. What measures should we consider to create long-term links between our planning group and service providers?

4. What geographical area do we propose to serve and what is its population?

5. How many people in our area are drinking at moderate to high-risk levels? Using illegal drugs? Misusing prescription drugs? Using inhalants or solvents to get high?

6. How can we describe each of these populations in terms of age, gender, ethnicity, culture, medical/psychiatric requirements, disabilities and other unique requirements?

7. What factors (e.g., socio-political and economic) will influence these populations over the next five to 10 years?

8. Which of the following resources exist in our community, and which of our needs can each resource address?

- hospitals and other health care facilities
- addiction treatment agencies
- residential and non-residential community services
- professionals and volunteers.

9. **What needs do we have that our current resources cannot address?**

EXAMPLES FROM TIMISKAMING

When a need for withdrawal management services was expressed in the Timiskaming district, the Timmins Area Office of the Addiction Research Foundation began by identifying individuals and organizations who were aware of people in need, including the major sources for referral in the area. The process of identifying these partners and assessing need encouraged the community to develop withdrawal management services. The members of the Timiskaming Detoxification Planning Committee represent law enforcement, hospital staff, physicians, addiction services, municipal welfare, clergy, the school system and the volunteer network.

During the proposal development stage, Timiskaming planners will bring together key players in the district, including members of the new District Health Council, people from health and social services, workplace representatives, volunteers, educators, members of community recreational organizations, and law enforcement officers. The planners anticipate that these consultations will lead to a permanent alliance, which will include the withdrawal management service. This alliance will organize the development of a comprehensive system of health recovery and promotion, as well as provide advice to the withdrawal management service.

As mentioned earlier, Timiskaming planners used quantitative and qualitative indicators to assess need, to demonstrate that the community would benefit from having local withdrawal management services and to show that a service plan should be developed. The planners reviewed the number of licensed drinking establishments in the area, hospital separation rates, the rate of alcoholism and consumption of alcohol in the population, the number of intoxicated clients at referral sources (by age, sex, gender, language/culture), alcohol and drug-related legal charges, and Rush's formula for estimating service capacity. A questionnaire obtained qualitative information about the perceived need for detoxification services, and explored current referral patterns and resources for providing detoxification. It also asked for suggestions to help set priorities and define the target population.

The Timiskaming Detoxification Planning Committee has identified the following resources in the district:

Hospitals
three community hospitals serving an area of about 40 kilometres each; also, North Bay has a psychiatric hospital serving Timiskaming.

Addiction treatment resources
Harmony House, a short-term residential treatment program, and an assessment service provided by the Timiskaming Health Unit; Timiskaming residents also have access to a 28-day treatment program, Jubilee Centre, in Timmins, and St. Joseph's Treatment Centre in North Bay.

Additional resources
existing outpatient services, general practitioners, walk-in clinics, the Victorian Order of Nurses, the self-help network (e.g., Alcoholics Anonymous) and hostels (e.g., Salvation Army).

The Planning Committee has identified the following gaps in Timiskaming:

- services for managing withdrawal
- family support services before and after withdrawal
- outpatient counselling
- psychiatric beds for people with a dual diagnosis (a psychiatric and a substance use disorder)
- community action in health promotion
- volunteer training
- identification and referral of people with substance use problems
- recovery home
- holding beds
- life skills training for recovering people
- ways to reach people who may find it difficult to get help, such as women and youth.

CHAPTER 3
THE PLANNING FRAMEWORK

This guide offers a flexible planning structure that can incorporate a range of methods for meeting the needs in your community. In this chapter, we define the target population and the objectives for withdrawal management services.

TARGET POPULATION

In general, withdrawal management services try to reach people who need assistance during withdrawal – rather than all people who are having problems with alcohol or drugs and require special services. "Needing assistance" is usually defined according to the severity of the client's physical dependence. The World Health Organization states that, "As a rule, detoxification is called for only when severe withdrawal symptoms are expected to occur following a quick return to abstinence or minimal drug use."[27]

Not all people who have problems with alcohol or drugs require detoxification.

Although the clients of detox centres include people with severe physical dependence, they also include people who are intoxicated or in crisis about alcohol and drugs but may not be severely dependent. However, we suspect that the target population defined for detox centres could be expanded even further. More and more people are referring themselves to detox centres, a trend that indicates that people at less risk and with less severe symptoms may require help during withdrawal. Most addiction treatment agencies require that clients be "substance-free" or "detoxed" for a specific period before entering the program (four days, for example). Before beginning treatment and during withdrawal, people may seek help from family, friends or an allied health professional. Not all of them enter detox centres. These people represent an opportunity to expand the target population if the service offers several methods of managing withdrawal.

Severe physical dependence is not the only indicator that assistance during withdrawal will be required.

Based on the research, the current mandate for detox centres, and available statistics, we provide a working definition for the target population. Planning groups can refine it to reflect their communities' needs. This definition is descriptive of current detox centre

We have identified four types of people as the target population for withdrawal management services.

clients, and represents previous and current mandates for the urban detox model. It also includes people who do not often enter detox centres, but who require assistance in order to remain abstinent for long enough to qualify for continuing treatment. We suggest that four main groups of people need withdrawal management services:

GROUP 1
Those who are intoxicated or in withdrawal from alcohol and/or other drugs in public places and are causing distress or disruption, or are otherwise putting others or themselves at risk. People in this group would most likely be referred to withdrawal management services by the police.

GROUP 2
Those checking into hospitals and other health care settings who are intoxicated or in withdrawal from alcohol and/or other drugs, but who do not require (or no longer require) emergency medical or psychiatric help. People in this group would most likely be referred to withdrawal management services by the medical community.

GROUP 3
Those who have been instructed to complete withdrawal so that they can begin specialized addiction treatment or services, but whose level of dependence on a substance, or on a combination of substances, makes it difficult or unsafe for them to withdraw alone and without assistance. People in this group would most likely be referred to withdrawal management services by helping professionals and addiction treatment agencies.

GROUP 4
Those who wish to complete withdrawal but whose level of dependence on a substance, or a combination of substances, makes it difficult or unsafe for them to withdraw alone and without assistance. People in this group would most likely be referred to withdrawal management services by family or friends, or would refer themselves.

The descriptions of Groups 3 and 4 stipulate that the client's problems with substance abuse must be so severe that the person needs assistance during withdrawal. Such problems include physical dependence, psychological dependence and social problems related to alcohol and/or drug use. Withdrawal management services do not target people who may require a supportive environment for other reasons. These people are best served by other social programs so that withdrawal management services can focus on alcohol and drug problems. Those who can help themselves by reducing drinking and engaging in ongoing counselling, for example, are not considered candidates.

Planning is easier when these groups are divided into subgroups. In the subgroups, you can specify particular characteristics, such as dependence severity, geographical location, cultural background, substance(s) used, areas of special concern (for example, a medical or psychiatric condition, or dependant care considerations), and availability of social supports, as well as the basic data required by the Ontario Ministry of Health: age, gender, referral source, admission/readmission.

OBJECTIVES OF WITHDRAWAL MANAGEMENT SERVICES

When defining the objectives for withdrawal management services, we considered the 1992 Ministry of Health mandate for detox centres, the care provided in detox centres, research findings, and our working definition of the target population.

As its goal, a withdrawal management service will contribute to a continuum of addiction services that encourages recovery and discourages relapse. This philosophy is supported by a number of short- and long-term objectives that describe the expected outcome of the service. These outcome objectives are reviewed below to show how they relate to one another. They are followed by our proposed service framework, which includes implementation objectives. Chapters 4 to 7 discuss these implementation objectives at length and illustrate them with practical examples. This discussion is organized under four headings: Service Awareness (Chapter 4), Assessment (Chapter 5), Managing Withdrawal (Chapter 6) and Planning for Continuing Treatment (Chapter 7).

LONG-TERM OUTCOME OBJECTIVE 1

To reduce the use of other services and settings for managing withdrawal

To achieve the first long-term objective, withdrawal management services will work towards these short-term objectives:

- increase understanding in referral sources of withdrawal management services (Service Awareness);
- increase the number of withdrawal management care plans that clients find acceptable (Assessment);
- increase the number of clients who have access to appropriate services (Managing Withdrawal).

LONG-TERM OUTCOME OBJECTIVE 2

To reduce the incidence of disruption caused by substance abuse

To achieve the second long-term objective, withdrawal management services will work towards these short-term objectives:

- reduce police interventions, legal charges and hours spent in jail associated with the service target group (Service Awareness);
- increase understanding of the client's needs (Assessment);
- reduce the number of complications occurring during withdrawal (Managing Withdrawal);
- increase compliance with any recommended medical procedures (Managing Withdrawal).

LONG-TERM OUTCOME OBJECTIVE 3

To reduce the cost per person of withdrawal management services

To achieve the third long-term objective, withdrawal management services will work towards these short-term objectives:

- reduce the number of patients admitted to hospital or seen in emergency who are identified as being intoxicated or experiencing withdrawal (Service Awareness);
- increase the number of withdrawal management care plans that are minimally intrusive and cost-effective (Assessment);
- increase the number of people who complete withdrawal (Managing Withdrawal);
- increase the number of clients completing withdrawal who enter a treatment or assessment/referral service (Planning for Continuing Treatment).

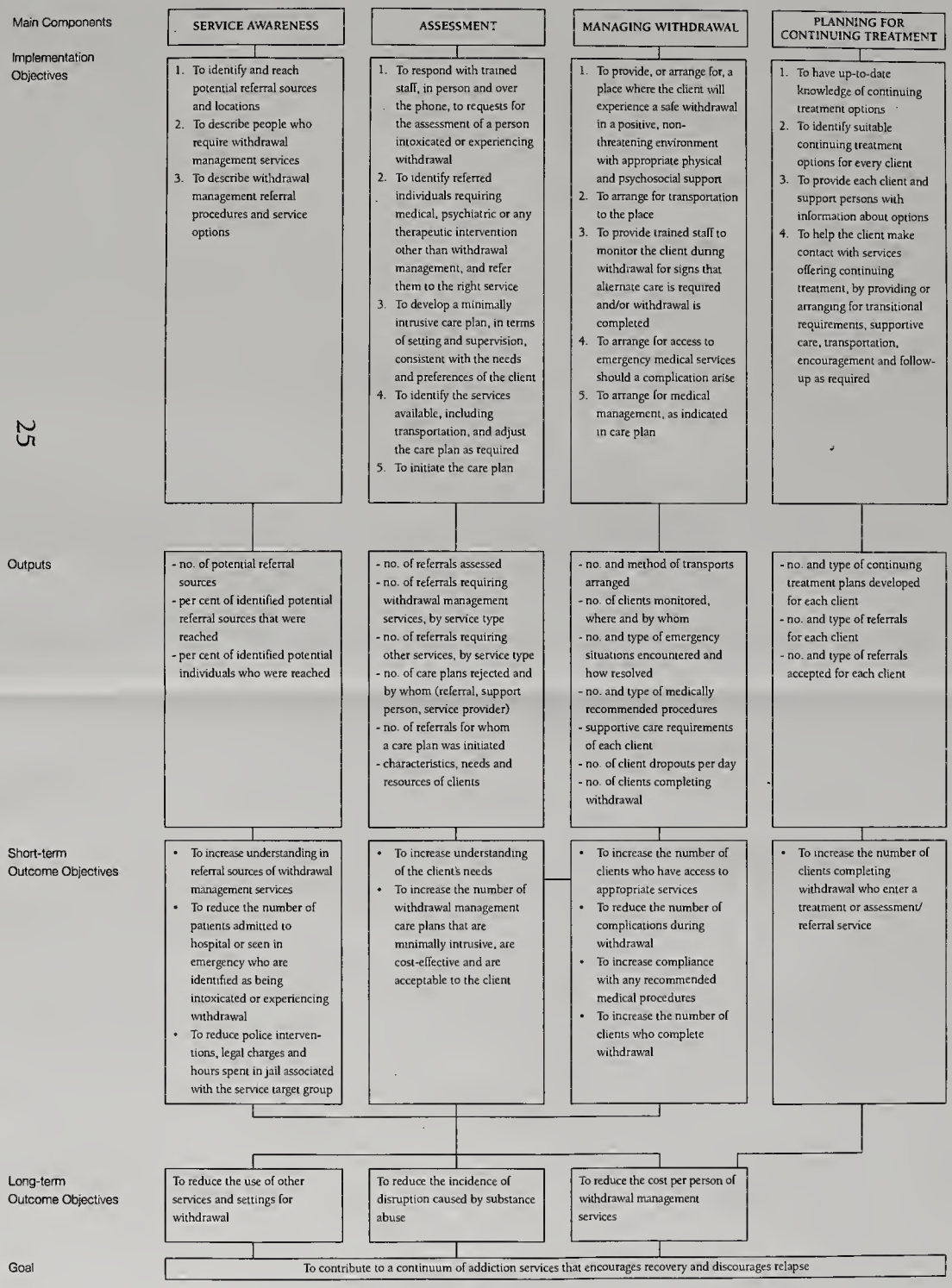
Our service framework is summarized in a logic model to facilitate service planning and evaluation.

It is challenging to plan services in a community group. Some planners find it easier if they have a structure for organizing all the information that needs to be discussed and all the decisions that need to be made. On page 25, there is a chart which Timiskaming planners used as a guide. We developed the chart to help us organize our information. The chart (a "logic model"[28]) summarizes the framework we propose for planning, and:

- identifies groups of activities performed by your service *(main components)*
- outlines specific activities that fall under each group *(implementation objectives)*
- describes the data to collect and analyze for evaluating or monitoring progress *(outputs)*
- defines objectives for the service *(short-term and long-term outcome objectives)*
- states the purpose or mission of the service *(goal)*.

Our framework can help your group to plan a service that is consistent with its objectives. The chart shows how activities are linked to objectives. As you write your funding proposal, you can refer to the chart for examples of what your service will accomplish and how it will meet its goals. The chart also specifies what your service should document and monitor, which could help you evaluate the service down the road. Proposal writing and evaluation are discussed in Chapter 8.

PLANNING FRAMEWORK FOR WITHDRAWAL MANAGEMENT SERVICES



S U M M A R Y

Ask the following questions in your planning group to fill out the planning framework with specifics about your community. Timiskaming planners have completed this exercise and offer some examples.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. **How many people in our community are:**

- **identified by law enforcement as candidates for withdrawal management?**

- **identified by hospital staff or other health care workers as candidates for withdrawal management?**

- **instructed by addiction treatment agencies to undergo detoxification prior to entering treatment?**

- **identified by family, friends, themselves or volunteers as candidates for withdrawal management?**

2. **What are the unique needs of each of these client groups?**

3. Who else can we talk to about identifying candidates for withdrawal management? For example, can we talk to social services, such as seniors' support and women's shelters, mental health care, correctional services, and Employee Assistance Programs?

4. Who else needs withdrawal management services, but is not currently getting them?

5. What barriers do we need to remove so that these people will access our service?

6. By implementing this service, to what degree will our community:

- reduce the use of other services and settings for withdrawal?

- reduce the disruption, distress and risk caused by alcohol and drug problems in our community?

- **reduce the cost of substance use problems in our community?**

7. What short-term objectives can we set for our community to reduce: the use of other services and settings for withdrawal; the disruption caused by substance abuse; and the cost of these problems?

EXAMPLES FROM TIMISKAMING

Timiskaming planners identified a number of people in their communities who in the past have not received the services they needed. These include women, youth, people in remote areas, single parents, cocaine users, victims of abuse, seniors, physically or mentally disabled people, individuals whose substance-use problems have not yet drawn attention, and families of people who need help during withdrawal.

The planning group also identified the following needs: methods to overcome distances and weather conditions; strategies for reducing stigma and denial; services that respond to the unique issues of women, youth and seniors; an enhanced role for health and allied health services in identification, referral, withdrawal management and ongoing support; and increased skills in families for coping and supporting recovery.

Timiskaming planners are addressing these needs in four service components adapted from this planning guide: Service Awareness/Community Development, Transportation, Assessment and Withdrawal Management, and Aftercare Planning.

They have established the following program and client objectives.

Program Objectives

1. To increase the number of people referred for specialized alcohol/ drug withdrawal management and related problems.
2. To reduce the incidence of disruption in families and the community caused by substance abuse.

3. To reduce the per person cost of withdrawal management services.
4. To increase the number of professionals, volunteers and planners throughout Timiskaming who provide withdrawal-related services.

Client Objectives

1. To increase the number of people completing alcohol/drug withdrawal in a safe, non-threatening environment.
2. To increase the number of people who participate actively in the development of their care plans.
3. To increase the number of clients who establish links with services providing continuing treatment.
4. To increase the number of clients who participate actively in continuing treatment and support.

In Chapter 8, we describe the outcome criteria that accompany each of these objectives.

CHAPTER 4
SERVICE AWARENESS

OBJECTIVES

Impact of Service Awareness

1. Increased understanding in referral sources of withdrawal management services.

2. Reduced number of patients admitted to hospital or seen in emergency who are identified as being intoxicated or experiencing withdrawal.

3. Reduced police interventions, legal charges and hours spent in jail associated with the target group.

In the service framework we propose, the following activities will achieve these objectives:

- To identify and reach potential referral sources and locations;
- To describe people who require withdrawal management services;
- To describe withdrawal management referral procedures and service options.

Activities designed to promote an awareness of the service are described in recent publications and are based on social marketing techniques.

Service awareness has not been considered a primary function of detox centres in the past. However, articles have been published that describe activities relating to this component, including educating potential referral sources, encouraging referrals to withdrawal management services and identifying the target population of the service. A campaign promoting awareness of the service requires resources, but it will help planners to ensure that the service is used by as many people as possible. The Ministry of Health has published a workbook that you may find useful. *Social Marketing in Health Promotion: A Communications Guide* describes a six-step system and provides worksheets for each step.[29]

IDENTIFY AND REACH POTENTIAL REFERRAL SOURCES AND LOCATIONS

As a first step, a service awareness campaign will identify and reach a broad range of local referral sources.

A campaign for service awareness can reduce the disruption caused by substance abuse by promoting the early identification of people needing assistance during withdrawal. Service awareness activities are most important for those who have contact with possible clients before police or hospital intervention, such as teachers, employers and primary health care workers. Sources of referral to withdrawal management services may vary from community to community, but could include police, hospital staff, family doctors and community nurses, community leaders, the general public (people who will refer themselves, family, friends), addiction treatment professionals, teachers, social service workers, correctional services staff, bar and restaurant employees, probation and parole officers, spiritual leaders and employers.

The campaign will develop a series of messages which build upon the knowledge level of each group of referral sources.

Different referral sources will have different levels of experience with substance abuse problems. In your campaign, it is important to tailor materials to fit each group of sources, so that people will participate in the process and learn how to make appropriate referrals. For example, police and hospital staff will not need to discuss the problems caused by substance abuse. But they may appreciate upgrading their skills in recognizing candidates for withdrawal management, and may benefit from reviewing the mechanics of how to refer people needing help to the local service. On the other hand, if you are approaching schools or businesses, you may consider developing an education component that discusses general substance abuse issues.

Customized service awareness activities which use existing channels for education will encourage the participation of referral sources.

A successful campaign selects media, times and places that will reach the greatest number of people, and encourages them to take part. Most organizations and communities already have facilities and resources for educating large groups of people; using these channels can also encourage participation and increase opportunities to reach referral sources. For example, hospitals conduct "inservices" and "Rounds" (seminars); schools have professional development days and auditoriums; small and large businesses hold regular staff meetings; small communities may hold seasonal community events, municipal councils or spiritual meetings. These are cost-effective ways to reach different groups of people who share the same level of experience with substance abuse.

Another way to increase participation is to match printed material to each referral source by describing examples of what they might encounter in their specific setting. You could supplement this series of printed materials with generic information provided through more expensive media, such as videos, public service announcements on radio or television, and slide shows. In your community there may be opportunities to get free publicity for the service, or corporate sponsorship for the campaign, and planners will want to explore these possibilities first.

Language and other cultural considerations will likely arise when planners are preparing pamphlets or oral presentations. For example, although the official languages of Ontario are English and French, a community may actually speak Finnish and Ojibwa, as is the experience of the Thunder Bay Detox Centre. Finally, endorsement by a professional association or licensing body (such as the Ontario Medical Association) can encourage professionals to pay attention to your message.

DESCRIBE CANDIDATES FOR WITHDRAWAL MANAGEMENT

In order to describe candidates for withdrawal management, you will build upon a well-developed needs assessment and a detailed definition of the target populations in your community. These descriptions are for potential referral sources and must be clear, precise and plainly worded. They should define who your customer is, what your customer's likely behaviors or activities are, where your customer is likely to be and when (time of day, week, year), and, lastly, how and why your customer will access your service.

Use these questions to describe your customer: Who? What? Where? When? How? and Why?

The working definitions of Chapter 3 could be expanded by adding local details. For example, when describing Groups 1 and 2, planners could name specific police jurisdictions and hospital areas. For Groups 3 and 4, you could provide guidelines for determining when a person should not try to withdraw from alcohol or drugs alone. These guidelines might include questions to ask about the number of previous attempts at withdrawal; the physical symptoms and other difficulties experienced during previous withdrawal attempts; or the client's history of drinking or drug use that could reveal the severity of his or her physical dependence.

DESCRIBE THE REFERRAL PROCEDURES AND SERVICE OPTIONS

A thorough description of the target population will help planners to develop referral procedures. For example, a subgroup that resides in a remote area may need special outreach strategies, or may have to wait longer for service than another subgroup. A candidate who also has a medical disorder may require a doctor's assessment as part of the referral procedure. Planning groups will devise referral procedures and service options according to what their communities need, so procedures and options will differ from community to community. However, the result will be the same – improved access to the service.

A toll-free telephone number to reach withdrawal management staff will encourage referrals.

A substance abuse hotline may encourage people to refer themselves to withdrawal management services. Those without easy access to primary health care or who may be sensitive to the social stigma (such as women and members of some ethnic groups) might be more likely to use the telephone to reach out for help. In regions where crisis intervention hotlines already exist, it may be possible to train hotline staff in referral procedures – a cost-effective way to help people reach withdrawal management services. A toll-free number to reach detox staff will also encourage helping professionals to call on behalf of their clients and patients. Existing detox centres could provide 24-hour telephone crisis intervention, and liaise with local withdrawal management services.

When considering a hotline or a toll-free number, however, planners should be aware of the possible obstacles. For example, in very remote areas, people may have only limited access to a telephone. In other areas, a service that requires touch-tone may not be effective. Finally, if a rural area is only served by party lines, people may not use the hotline because of lack of privacy.

To maximize the use of the service, planners may consider ways of "finding" clients.

"Finding" clients may also be part of a campaign to promote the service. For example, the 1988 Ministry of Health publication *A Framework for the Response to Alcohol and Drug Problems in Ontario* suggests that "street patrols can be initiated in certain neighborhoods to identify known drug users who need medical help." Saskatchewan's Mobile Treatment Unit spends a week in remote communities to identify candidates for their service. Seeking clients directly is considered less important in cities, but finding referrals in small urban, rural and remote areas may help to put your service to the greatest use. For populations in very remote areas, planners could consider an outreach activity like the Mobile Unit described later in Chapter 6.

A service awareness campaign can begin to allay fears and reduce misconceptions by telling people what to expect.

Simply creating ways for referral sources to access the service, such as a hotline or mobile unit, is not enough. Planners must also tell people where these access points are, how to use them and what to expect when they do use them. This information, which could be provided in pamphlets, newspaper advertisements and posters, could act in conjunction with other media, such as public service announcements, to allay fears and reduce misconceptions about the process of withdrawal. To reach people with lower than average literacy skills and with first languages other than English and French, you will need to use your resources creatively. For example, a peer referral system or visual media may work better than pamphlets.

S U M M A R Y

Ask these questions in your planning group to discuss how you will create awareness of your service and encourage people to access it. Timiskaming's plans offer an example.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. What are the important referral sources in our community, and how much do they know about withdrawal management?

2. How can we reach these referral sources? What methods of communication should we use, which languages, what content and format of materials, which presenters, etc.?

3. What steps will we take to:

- **promote service use?**

- **help referral sources to identify people who need our service?**

- increase access to our service?

- allay fears and reduce misconceptions about the service?

4. What media are available to us and which of these will give us free publicity?

5. What education channels currently exist in our community, and who can we contact about using them?

6. What funds will we need in order to take advantage of the media and education resources in our community?

EXAMPLES FROM TIMISKAMING

The priority referral sources include organizations that deal with clients experiencing acute alcohol/drug problems (hospitals, law enforcement, probation/parole, self-help, clergy, families, addictions services), as well as groups that could intervene early and offer less intrusive services (schools, workplace, clergy, social services, public health). The Timiskaming planners hope to focus in particular on families needing help to cope with the user, assist during withdrawal and adapt during recovery.

In order to select appropriate content, format, delivery methods and presenters for its campaign, the Timiskaming planners have created a communications plan that includes breaking the audience into groups, finding out more about the people they hope to reach, and developing and testing media messages.

To improve access to the service, they also plan to train referral sources to identify and refer people who need help.

CHAPTER 5
ASSESSMENT

OBJECTIVES

Impact of Assessment

1. Increased understanding of client's needs.

2. Increased number of care plans that are minimally intrusive, are cost-effective and are acceptable to the client.

In the service framework we propose, the following activities will achieve these objectives:

- To respond with trained staff, in person and over the phone, to requests for the assessment of a person intoxicated or experiencing withdrawal;
- To identify referred individuals requiring medical, psychiatric or any therapeutic intervention other than withdrawal management and refer them to the appropriate service;
- To develop a minimally intrusive care plan, in terms of setting and supervision, consistent with the needs and preferences of the client;
- To identify the services available, including transportation, and adjust the care plan as required;
- To initiate the care plan.

Assessments will help your service to achieve its objectives by anticipating a client's needs and reducing complications. For example, assessments can allow you to create a care plan that supports the client's need for medication, supportive counselling or respite from difficulties at home. Identifying these needs reduces the number of complications that arise during withdrawal management, including the client's non-compliance. Assessments also build upon the resources available to the client, such as a supportive family member, employment, motivation for change or relatively good physical health. Awareness of the client's resources helps you create a care plan

that is cost-effective and minimally intrusive. Furthermore, staff will only choose expensive or intrusive types of care when they have explored all other safe options with the client and support person, and decided against them.

RESPOND WITH TRAINED STAFF

Training will promote a standard assessment technique, allowing the service to use a mix of health and allied health professionals, volunteers and specialized addiction staff.

Withdrawal management services provide trained staff to respond to requests for assessment by referral sources. However, they do not necessarily hire staff whose sole purpose is to perform assessments. In the urban model, for example, the people who monitor and counsel the client during withdrawal also respond to requests for assessment. Training is the key requirement and will promote a standard assessment technique. With proper training and a standard assessment tool, non-addictions professionals can participate in the withdrawal management service and perform assessments according to policy. A mixture of specialized staff, trained volunteers and health care or social services professionals could work together in a network to provide a 24-hour service. In some communities, however, round-the-clock availability may not be practical, so planners may choose specific times of the day, week or year when staff will be on hand to respond, and other times when a staff member will be on-call. You could also consider the use of existing detox centres to provide toll-free, 24-hour hotline services.

IDENTIFY CLIENTS WHO REQUIRE MEDICAL INTERVENTION

A basic assessment of the client's physical and psychiatric condition will determine whether he or she should be referred to hospital for medical attention.

Once a trained staff member has responded to the request for assessment, the second assessment objective is to identify and refer to hospital anyone who requires immediate medical or psychiatric attention. The staff member will need to assess the client's physical and psychological condition, and look for obvious signs of serious problems. Currently, detox centre personnel conduct these primary assessments, as do police and ambulance attendants in urban communities; a physician is not required. We recommend, however, that staff be properly trained by a team that includes both health and mental health care professionals. Part of their training could be how to identify an existing or imminent medical/psychiatric emergency and how to support and stabilize the client until help arrives. Planners will wish to involve physicians, paramedics, ambulance attendants and emergency nursing staff, as well as psychiatrists and police, in the preparation of this training.

In rural and remote areas and small urban centres, resources for providing special care (such as for an acute psychotic episode) are scarce. In these communities, therefore, responding appropriately becomes very difficult. Nonetheless, dealing with medical and psychiatric emergencies is not an objective of withdrawal management services. The staff's responsibility is to identify these emergencies, alert the medical community and ask for help. Planners must ensure that any client who needs medical assistance will receive it promptly.

Referrals requiring urgent medical or psychiatric attention are not candidates for withdrawal management services until the emergency has been addressed by the medical community.

The presence of alcohol and drug problems in people who have psychiatric disorders is an area of growing concern, and has troubling and complex implications for delivering a withdrawal management service. We believe that difficulties in this area can only be overcome with full co-operation from the medical establishment. Co-ordinated efforts to help clients with concurrent disorders must be encouraged and supported in every community, whether urban, rural or remote. Planners face a number of complex issues, including clients with cross-addictions, dependence on anti-depressants, and symptoms that could be caused by addiction *or* by a psychiatric disorder. To address these issues, they must link addictions and mental health resources in the community in order to train staff and to help clients. Provincial research and funding should support these efforts.

Ontario's detox centres provide some guidance. First, each detox centre is sponsored by a hospital, which ensures the co-operation and support of the medical community. Second, only a small number of clients require emergency medical attention. Detox centre statistics for March 1993 indicate that four per cent of the clients were referred to hospital for medical treatment[30]; in January 1993, it was two per cent. Detox centre clients are sent to hospital when, for example, they are diabetic but do not have proper medication, they are experiencing chest pains or they are complaining of a sore arm after a fight. Third, the training course for detox centre staff, developed by members of the Ontario Detox Directors' Association (ODDA) and the Addiction Research Foundation, provides a step-by-step procedure for responding if a client has a seizure. One of the first steps is to get medical help.

DEVELOP A CARE PLAN

The third objective of assessment is to develop a withdrawal management care plan that is minimally intrusive, in terms of setting and supervision, and that reflects the client's needs and preferences.

Staff will first need to identify which clients are likely to require inpatient medical help to manage their withdrawal symptoms, and to obtain a physician's assessment for them. A small number of clients will require detoxification in a medical facility. In addition to getting their clients to hospital for medical attention, detox centres referred another two per cent in March 1993 to hospital for withdrawal

If a client has a history of seizures or delirium tremens in previous withdrawal attempts, he or she should be referred to an inpatient medical facility for managing withdrawal.

management; in January 1993, it was four per cent.[31] The literature provides guidelines for determining when inpatient hospital treatment will be required for safely managing alcohol withdrawal. Dr. Nabila Beshai suggests that if a client is having severe withdrawal symptoms and has a history of very severe symptoms, he or she should be referred for at least temporary inpatient, medically managed withdrawal. Beshai also recommends the assessment of two other risk factors: use of psychotropic drugs in combination with alcohol, and recent drinking level. She says:

> The patient's withdrawal condition at intake (abnormal blood pressure[32] and pulse), and a history of severe withdrawal symptom[at]ology warrant referral to a medical facility, at least for temporary treatment. The intake of psychotropic drugs should be assessed since they increase the possibility of experiencing seizures. Current use of alcohol should be investigated because the relation of alcohol use to seizures is causal and dose dependent.[33]

People with severe concurrent medical disorders (physical or psychiatric) should probably be referred to a medical facility for inpatient management of withdrawal.

Another study, by Webb and Unwin[34], identified four factors that the writers claim predicted when people dependent on alcohol required inpatient care under medical supervision (as opposed to *outpatient* detoxification under a physician's care). The four factors that Webb and Unwin identified are these: a Severity of Alcohol Dependence Questionnaire (SADQ)[35] score of 35 or more; consumption of at least 40 cigarettes a day; 50 years of age or older; and a severe current medical disorder (physical or psychiatric). In their study, these four factors had a cumulative effect; that is, people with three of these factors had an 86 per cent chance of admission for inpatient detoxification. People with fewer than three factors had an 84 per cent chance of completing withdrawal on an outpatient basis. The results of this study must be interpreted with caution: age will be related to dependence severity when there is a longer drinking history, while smoking increases the likelihood of concurrent physical problems. The most relevant of these indicators, in our estimation, is the fourth – severe current medical disorder (physical or psychiatric).

Once planners have identified the circumstances in which the staff should obtain inpatient medical care for clients, they will next need to consider when staff can recommend the other care options provided by the service. Selecting the appropriate level of care, in terms of setting and supervision, will increase the effectiveness of the service and reduce costs in the long term.

Standardizing Assessments

We support the development of a standard technique for assessing and monitoring the client during withdrawal.

The planning documents that we reviewed not only call for rural detox options, but repeatedly recommend the design and implementation of a standard instrument for initial assessment[36] We agree, and believe that this standard assessment technique could help staff select different methods and settings of withdrawal management services. A standard instrument has a number of benefits for planning and delivering the service:

- It reduces the number of decisions made with subjective data and increases consistency.
- It is cost-effective. Standardized assessments reduce the need to consult with others, so fewer staff are required at the assessment stage and the process is completed more quickly.
- When used for training, it will increase the staff's previous experience with substance abuse, and will help them to achieve accurate results quickly.
- It may be especially valuable for people who work in isolation from peers and other supportive networks.

The benefits of a standard assessment technique include increased consistency and reduced costs.

A standard instrument for assessment would help groups in rural and remote areas and small urban centres to plan and deliver efficient and effective services. It would allow them to capitalize on their resources. For example, a standard assessment tool can streamline referrals from the medical community. A doctor will be able to provide the client with both the stitches required for a cut and a withdrawal management assessment. The client may also receive a prescription for a sedative if the doctor decides, using both a standard withdrawal management assessment instrument and medical experience, that the client needs this level of care. Particularly in regions with limited resources, it might make more sense for health care workers in the community to assess clients themselves, and save the service the cost of hiring additional staff.

A standard instrument for withdrawal assessment will prove especially valuable to small urban, rural and remote communities.

We looked at a variety of sources for a standard tool that could anticipate the level of care a client needed, and would be suitable for Ontario's small urban, rural and remote areas. We chose two instruments for discussion in the next section of this guide, but planners may also benefit from studying two other sources.

We have attempted to identify a standard instrument suitable for use in rural and remote areas and small urban centres.

In February of 1993, the Addiction Research Foundation completed a *Directory of Client Outcome Measures for Addictions Treatment Programs*.[37] In this resource book, "a number of standardized measures for assessing particular life areas of client functioning following treatment" are reviewed. Part 3 (pages 50-78) presents the results of a critical review of two instruments used to measure dependence severity, the Short Alcohol Dependence Data (SADD)[38] and the Alcohol Dependence Scale (ADS).[39] It states that these two instruments "measure the alcohol dependence syndrome in a way that is broadly applicable to most addictions treatment populations" and that they were "among the most useful and meaningful tools currently available for measuring adverse consequences." The focus of the review was to determine whether the instruments accurately measure treatment outcome, and was not concerned about their ability to predict appropriate levels of withdrawal management service or to monitor withdrawal symptoms.

Beshai also reviewed a number of scales for assessing the severity of the alcohol withdrawal syndrome[40] which have been used in studies for client-treatment matching, in some cases for detoxification options.[41] At this time, there is no comparable review of instruments suitable for use with substances other than alcohol.[42]

Two Standard Instruments for Assessment

We have identified two instruments for further study.

We selected two instruments for possible recommendation. The CIWA-Ar[43] was developed at the Addiction Research Foundation, has been tested extensively and is currently used to monitor withdrawal symptoms and determine the extent to which medication is required. The Severity of Alcohol Dependence Questionnaire (SADQ)[44] also looked promising. It has been used in research studies to correlate dependence severity and the level of care required by the client, and it also plays a role in delivering home detoxification services in other countries. A copy of each of these scales is included in Appendix 2. Although we can't recommend either instrument without qualification, they are both useful scales, and should be studied further.

The CIWA-Ar scale is used to quantify withdrawal symptom severity and to monitor response to treatment.

At the Addiction Research Foundation's Clinical Research and Treatment Institute in Toronto, the CIWA-Ar assessment instrument has been used for the systematic assessment of withdrawal symptoms and the monitoring of a client's response to treatment. The CIWA-Ar scale inquires about 10 symptoms: nausea/vomiting, tremor, paroxysmal sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache/fullness in the head and orientation/clouding of sensorium. This information is supplemented by pulse and blood pressure. We considered the CIWA-Ar promising for several reasons:

- Using the CIWA-Ar scale, staff can quantify the severity of withdrawal symptoms, and physicians can decide on the need for supervision and medication.
- With modifications, this scale can be used with drug dependence problems.
- Trained staff can apply this scale in a few minutes.[45]
- The CIWA-Ar has been used in different cultures and languages (in France, Italy, Spain, Belgium and Chile) with no effect on its ability to predict withdrawal severity.
- Inter-rater reliability, the reliability of the scale when used by different people, is high.

The SADQ has been used in a variety of studies to assess alcohol dependence, and is currently used in the delivery of home detox services.

Tim Stockwell's Severity of Alcohol Dependence Questionnaire (SADQ) is an instrument that has been used in several studies to associate dependence severity with the care required during detoxification. The original questionnaire, published in 1979, includes 33 questions in the following five categories: physical withdrawal, affective withdrawal, withdrawal relief, typical daily consumption and the morning after two days heavy drinking following at least four weeks abstinence. We considered the SADQ for recommendation for these reasons:

- The scale was modified to a 20-item self-completion questionnaire, which is easy to use.
- A 1983 study[46] concluded, "Results to date indicate the SADQ is a quick, reliable and valid instrument for the assessment of degree of alcohol dependence."

- The scale is used to determine whether the home or the hospital setting is most appropriate for the client's level of dependence.
- The SADQ has been used extensively in home detoxification services, and is currently used in that setting.

Strengths and Questions

These instruments have several strengths on which to build: first, they have been tested and validated; second, they are currently used in a withdrawal management setting; and third, they can be quickly and easily completed. However, questions arise about whether these scales can be applied as monitoring or matching instruments in an expanded service. For example:

These instruments need to be used in the range of settings proposed in this planning guide before we can recommend them.

- In what way should the scales be used by different types of professionals and/or volunteers?
- To what extent can they be used over the phone?
- For different settings, how should the scores be interpreted, and by whom?

These are complex questions that deserve discussion and further study. For example, uncertainties remain about what the CIWA-Ar scores mean in terms of caring for the client. Guidelines for the CIWA-Ar scale suggest that the scores mean the following:

Questions remain about how the instruments should be used in relation to the staff, settings and procedures outlined in this guide.

- A score of 25 or over indicates severe withdrawal and that a physician's assessment and medication will be required.
- A score of 15 to 24 indicates moderate withdrawal symptoms. Medical care may benefit the patient and clinical judgment will decide the best course.
- A score of less than 15 indicates mild withdrawal. Providing the client has no history of seizures or delirium tremens, supportive care will be sufficient.

The originators of the CIWA-Ar scale recommend that severe withdrawal be assessed by a physician and medically managed. This recommendation is based on studies of clients undergoing detoxification in a medical facility. These studies indicated that 15 per cent of those experiencing severe withdrawal symptoms may suffer seizures or delirium tremens and that there is no sure method of predicting which clients will experience these life-threatening symptoms. On the other hand, the experience of detox centres raises a question about this recommendation. The average client in a detox centre will score over 25 using this scale, but receives neither a medical assessment nor medication to control symptoms. Furthermore, less than five per cent of people cared for in detox centres are referred to hospital for medical care of withdrawal. To decide if a client will need this level of care, detox centre staff look for warning signs of seizures (such as extreme agitation or disorientation, or a sudden onset of confusion). We suggest that the use of the CIWA-Ar by detox centre staff could provide answers to this question, and we

suggest further that the Ontario Detox Directors' Association (ODDA) and the Addiction Research Foundation collaborate in such a project.

The fact that these scales cannot be used over the phone raises another complex question. For rural and remote regions, telephone screening procedures are valuable because, wherever access is difficult, people may choose a hotline to reach the service. Both the CIWA-Ar scale and the SADQ require the client's physical presence. Conceivably, it may be possible for staff to identify people requiring emergency medical or psychiatric attention by speaking to them on the telephone. Alternatively, it may be just as obvious which clients have social supports and a withdrawal and drinking history suitable for detoxification at home. However, the majority of withdrawal management clients will not fall into these two categories. While the SADQ poses questions that could be answered over the phone, to our knowledge it has not been used in this way, and was not designed for this purpose.

We recommend that ARF put its resources into developing a standard assessment technique that will match clients in rural and remote areas and small urban centres to an appropriate type of care during withdrawal.

Without further testing, it is difficult to recommend either the CIWA-Ar or the SADQ for use in all the settings and circumstances proposed in this guide. We recommend a two-step process to the Addiction Research Foundation: (1) Develop an assessment instrument that can guide withdrawal management staff to select the level of care and setting required by clients. To be suitable for small urban, rural and remote areas, the instrument should be one that can be used over the phone by trained staff and volunteers, as well as health care professionals; (2) Test the CIWA-Ar and the SADQ within the context of the assessment instrument developed in the first step. A recent proposal by ARF scientist Helen Annis requested funds to take the first step, developing and testing an assessment instrument.

Interactive Assessments

During assessment, trained staff provide and obtain information so that an appropriate care plan can be developed, and this interaction between staff and clients guides us to an outline of what an assessment instrument should include. The research literature also identifies the types of information needed. We recommend that all withdrawal management assessments include:

- the client's vital signs and physical condition
- psychological condition
- drug and/or alcohol use and withdrawal history
- the home environment
- support person(s) – their existence, availability, attitude and preferences[47]
- the client's preferences for managing withdrawal.

Staff need to obtain this information from the client and the client's support person, where possible. With this information, they are able to create a picture of the nature and extent of the client's problems and anticipate the level of care he or she will require.

Staff should also provide information during the assessment about the client's condition, about what will happen during withdrawal, and about the client's choices for service. For example, the client and staff member can work together to identify the nature and extent of the problem.[48] This collaboration could help to win the client's and/or the support person's consent and co-operation, which will reduce conflict during withdrawal management and improve the opportunities for linking the individual with continuing treatment. Describing procedures and policies to both the client and the client's support person will help the client to complete withdrawal, and will dispel some inaccurate expectations about the service.

In communities where medical backup may be far away and round-the-clock monitoring by trained personnel is not available, it is essential to make a sound assessment in which both staff and client have confidence. Keep in mind that the client may not be able to provide all of the necessary information immediately. The service may need to have a cot or couch where he or she can rest or sleep for a few hours before completing the assessment.

Assessing Clients for Home Care – The Exeter Home Detox Model

The Exeter Home Detox model, developed in Exeter, England, uses physical and psychosocial indicators to determine suitability for home detox.

A practical example of how assessment is structured around a client's needs and resources is provided in the Exeter Home Detox model.[49] In this model, the people considered appropriate for home detox are those who are likely to experience severe withdrawal without complications and who need medication to withdraw safely from alcohol. A community psychiatric nurse (CPN) conducts the assessment during an interview, which is completed within 24 hours of referral, if possible. The criteria used to determine whether or not a person could benefit from home detox include these two questions. Is there any need for medication to cover withdrawal symptoms? And, if so, is there any strong reason for not keeping the client at home? To estimate how severe the withdrawal will be, staff use the SADQ in combination with a medical assessment by the client's family doctor. The CPN assesses the home environment.

The Exeter Home Detox assessment strategy's three parts are:

Their assessment strategy is:
- to establish need
- to assess risks
- to gain written consent.

- Establish need – that is, the client expresses a clear desire to stop drinking completely for at least a few weeks and staff anticipate severe withdrawal symptoms because of the client's recent alcohol and drug use history (quantity and frequency of alcohol use, barbiturates and tranquillizers).
- Assess risks – that is, the client has no history of withdrawal seizures, the family doctor confirms there are no other serious physical or psychiatric conditions, and the home is quiet, "not unsupportive," and free of drugs and alcohol.
- Gain written consent – that is, the client understands the procedure and gives consent, any close friend (including a "friendly landlady") or family member gives informed consent, and the doctor is willing to prescribe medication.

Matching Clients to Services – Maudsley Alcohol Treatment Service

The Maudsley Alcohol Treatment Service of London, England, offers a range of services and uses a comprehensive assessment to match the client with appropriate withdrawal management care.

An example of how assessments are used to select withdrawal management options is provided by the experience of the Maudsley Alcohol Treatment Service,[50] which offers a range of options for managing withdrawal. The initial assessment, which takes about two hours and is described as a "dynamic, interactive process," is not always completed in one session. It includes a physical exam and tests, as well as an interview with a relative or friend, if possible. When deciding on an appropriate withdrawal management plan, Maudsley staff take into consideration the degree of dependence, the range of alcohol-related problems, personality, accompanying psychopathology, physical state, social stability, marriage and the personal wishes of the client.

The assessment helps staff to make certain decisions:

- Medical problems are referred to the attached hospital.
- If the client is mildly dependent, either no drug treatment is provided, or a minimal and short-term outpatient course of chlordiazepoxide is prescribed.
- For more severe withdrawal symptoms, heavier medication is prescribed, and can be collected daily by the client from the hospital attached to the service. The patient's family doctor or a community nurse monitors withdrawal.
- Inpatient withdrawal management is indicated for incipient delirium tremens, a previous history of withdrawal seizures, risk of suicide, danger of violence to family, major accompanying psychiatric illness, extreme social instability (homelessness, for example), or, on occasion, "a need to sort out an otherwise unmanageable mess." Inpatient withdrawal is also advised when outpatient withdrawal is not working. About 20 per cent of the patients at Maudsley require inpatient care. For the Maudsley service, inpatient care is offered at a psychiatric hospital, with supervision by a doctor who determines the need for medication.

ADJUST AND INITIATE THE CARE PLAN

Staff will select service options based on the best information available. Your assessment instrument could include a procedure for adjusting the plan to meet service standards.

Without research to guide the selection of service options for individual clients, withdrawal management staff will use their best judgment and experience when developing care plans. However, they may need to adjust the preferred care plan to take various factors into account. Here are some possible factors:

- The client's support system – For some settings, the co-operation of these people may be essential. Therefore, with the client's permission, staff may have to consult family members and/or friends before initiating the plan.
- The client's safety and links to continuing treatment – Setting can affect safety and links to continuing treatment. For example, medication may be required in the home but not in a detox centre. Or visits to the home may be necessary,

if not for monitoring the client, then for linking him or her to further treatment.

- The availability of care elements, including specialized professionals – Before the care plan is initiated, staff will confirm that resources such as volunteers, transportation and beds are available, and that specialized staff will co-operate, as required. For example, a health care professional may be necessary to determine whether the client can be safely transported or whether medication is needed.
- The expected outcomes and required standards of the service – Assessment staff could include these outcomes and standards in the care plan, so that monitoring staff can quickly assess when they are not being met, and make adjustments.

S U M M A R Y

Ask these questions in your planning group to discuss how you will assess your clients' conditions and circumstances, and then match them to different service options. The example of Timiskaming may help you to explore this aspect of the service.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. Who will perform withdrawal management assessments in our community? What qualifications and training will they need?

2. Where and when will assessments of our clients take place?

3. How will we train the assessment staff? Who can help us with this training? Are there existing training programs that we could use?

4. How will we transport people to medical help in our community? Can we bring medical help to people in some settings?

5. Who decides when or whether it is safe to transport clients? How do they know?

6. How do we deal with psychiatric emergencies when people with psychiatric training are not available?

7. What should a care plan achieve for our clients?

8. What advantages will a standardized assessment technique give our service?

9. How can we help our clients to co-operate with the care plan?

10. What roles will the client's family and other support systems play in the care plan?

11. What standards of care do we wish to set for the withdrawal management phase of our service?

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EXAMPLES FROM TIMISKAMING

Assessments will take place at three kinds of locations in the Timiskaming district: homes; designated beds in facilities in five Timiskaming communities; and in appropriate settings provided by other organizations (homes for seniors, for example).

Professional withdrawal management staff will perform most of the assessments. In two locations where designated beds are located in health clinics, public health nurses (trained and supported by the service) will assess clients. In some cases of home detoxification, organizations that provide home care services to the community (such as the VON, Timiskaming Health Unit, and Timiskaming Home Care) may provide assessments.

Professionals who are temporarily drawn from services existing in the Timiskaming district will be trained by the withdrawal service and will report directly to the service when reassigned. A comprehensive training program will be developed in Timiskaming. It will align itself with the provincial training program for detox centre staff, and will be implemented in consultation with the following partners: Ontario Detox Directors' Association, Addiction Research Foundation, Northern College of Applied Arts and Technology, St. John's Ambulance, Contact North, TVO, Canadore College, Timiskaming physicians, Timiskaming Health Unit and Harmony House.

The training program will help service staff, volunteers and allied organizations to achieve common goals: identifying and referring clients, managing withdrawal, providing post-withdrawal support, helping families to cope with withdrawal and recovery, and encouraging the community to respond to important health recovery and health promotion issues.

Ambulances from three district hospitals will transport clients who need emergency medical services. Timiskaming planners anticipate that medical supervision will take place in hospitals, nursing stations, homes and other locations such as homes for

senior citizens. Health care practitioners will be available in these places to provide emergency medical services.

In psychiatric emergencies, clients will have a medical assessment and be referred to North Bay Psychiatric Hospital, 160 kilometres from New Liskeard. The district mental health plan, which is currently under consideration, would allow referral to local psychiatric beds.

As their care plans are developed, clients will learn more about their conditions, the operation of the service, and the opportunities for post-withdrawal support. An important part of this discussion, as soon as the client is able, will be the client's written agreement to abstain from substance use for two weeks. Staff and clients will also agree on the care plan's goals and withdrawal management options.

Professional withdrawal service staff will determine the transportation needs of the client using an assessment instrument. To increase safety and reduce liability, at least two people will be involved in transportation, one to drive and one to care for the client. Where necessary, transportation will be arranged through the ambulance system.

CHAPTER 6
MANAGING WITHDRAWAL

OBJECTIVES

Impact of Managing Withdrawal

1. Increased number of clients who have access to appropriate services.
2. Reduced complications during withdrawal.
3. Increased compliance with any recommended medical procedures.
4. Increased completion rate.

In the service framework we propose, the following activities will achieve these objectives:

- To provide or arrange for a place where the client will experience a safe withdrawal in a positive, non-threatening environment with appropriate physical and psychosocial support;
- To arrange transportation to the place;
- To provide trained staff to monitor the client during withdrawal for signs that alternate care is required and/or withdrawal is completed;
- To arrange for access to emergency medical services should a complication arise;
- To arrange for medical management, as indicated in the care plan.

Withdrawal is a physical and psychosocial process. When managing withdrawal, staff arrange the psychological and social influences on a client's life in a way that will support the physical process – the safe elimination of toxic substances from the body. Their job is finished when the client's health has been restored to some extent, and the client is ready for continuing treatment. In this complex process staff must: select an appropriate setting and provide a level of comfort that encourages the client to complete withdrawal; make arrangements for getting the service to the

client, or the client to the service; monitor the client; and enlist medical services when necessary for the client's safety. These activities are described in detail below. At the end of the chapter, we list the options for managing withdrawal.

PROVIDE A PLACE WHERE THE CLIENT WILL EXPERIENCE A SAFE WITHDRAWAL IN A POSITIVE, NON-THREATENING ENVIRONMENT WITH APPROPRIATE PHYSICAL AND PSYCHOSOCIAL SUPPORT

Appropriate places for withdrawal management are various, depending upon the client's needs and resources.

Withdrawal management services offer places where clients can rest, start feeling better, and think about what to do next. They also provide the elements of care required to ensure the client's safety during withdrawal, as defined by the assessment.

Appropriate settings encourage clients to continue their abstinence and complete withdrawal. They are *positive* – flexible, nourishing to the body and the mind, supportive of the client's strengths and motivation to change – and *non-threatening* – culturally sensitive and otherwise responsive to individual needs. At the very least, the setting selected must not undermine the client's ability to remain abstinent or discourage the client from pursuing treatment options.

The kinds and amounts of support a client will need is an aspect of care which will be identified by the assessment and evaluated during monitoring. For planning purposes, however, it is necessary to consider how to provide different types of care in each setting, including monitoring, emergency medical assistance, rest, nourishment, hygiene, privacy, daily activities, medication, transportation and emotional support. It is also important to estimate for how many days each type of care will be needed.

The duration of care will vary from client to client and setting to setting, but an average of five days can be used in planning.

How long a person needs care will differ from client to client, depending on the kind of substance or combination of substances the client was using, the intensity and duration of use, and the physical health of the client. For planning purposes, the average length of service could be five days. Detox centre statistics indicate that during 1992-93, the average number of days per client for all detox centres was three, with a range of average stays from two to seven days. One home detox service allows five to seven days to complete withdrawal and be referred to ongoing treatment. You should also allow time (over and above the five service days to complete withdrawal) for following up on clients as a way to encourage the changes they are making and as an opportunity to evaluate the service.

If these aspects of care are provided, withdrawal can take place in a client's home, a detox centre, a residential facility or a volunteer's home.

ARRANGE FOR TRANSPORTATION TO THE PLACE

Transportation can be viewed in two ways: transporting the service to the client and transporting the client to the service.

Staff must often arrange transportation to make withdrawal management services more accessible. Transportation has two purposes: getting the service to the client, and getting the client to the service.

The first purpose has not received much attention in Ontario because the formal system for withdrawal management is the detox centre, which requires that clients come to it. In general, volunteers and staff who monitor clients in their homes must have a car and be prepared to drive in all types of weather. To create a service that travels to the client, you will need to consider the amount of driving the staff will be expected to undertake and the associated costs, including gas, car maintenance and insurance. For example, providing a rural area with a home detox service, in which a trained community nurse visits clients in the home twice daily for three days and once a day for the remaining four days, may require a lot of travel. To create an effective service plan, we recommend that you divide your service area in a way that limits the amount of driving required.

The second purpose has received some attention. Transporting clients to the service is a particularly vexing issue for planning groups in remote areas of the province. It may be obvious that people who are intoxicated or experiencing withdrawal cannot transport themselves, but it is less clear how to set reasonable expectations for their transportation and how to create a transportation plan. Currently, family members, friends and self-help groups in many areas are driving clients, but it is difficult to systematically increase these modes of transport. For example, organized transportation systems, such as taxi companies, are reluctant to make commitments about transporting intoxicated clients over long distances.

We reviewed the efforts of one local planning group to establish a system for transporting clients to the service, as well as the effect these efforts had on policy-makers.

Rather than make a recommendation, we offer an example to illustrate some of the points for planning groups to consider. When the Smooth Rock Falls detox centre was opened in the north of the Cochrane district, planners made substantial efforts to address the possibility of transporting clients from district communities to the centre, and considered drives of up to 128 kilometres on an isolated road. They found that there was no model established in Ontario for transporting intoxicated patients, and that an informal transportation system, by friends, family and volunteers, was already in effect in some remote areas. Their attempt to establish formal transportation arrangements met with difficulties. However, in response to their work, the Community Mental Health Branch of the Ontario Ministry of Health established the following transportation guidelines in December, 1992:

- Assessment and referral staff are responsible for knowing transport options and offering to make transport arrangements.
- Police are authorized to bring clients only to the facilities designated in the Liquor Licence Act. (An Order in Council subsequently designated 29 detox centres in this list of facilities.)

- Ambulances may transport intoxicated individuals only if immediate or future medical attention is required, including medical attention during transport (according to the assessment made by ambulance attendants).
- At their discretion, detox centres may arrange or pay for transportation.

The Detox Transportation paper containing these guidelines concludes that transportation options should be considered in the following order: funded and organized by the client; supplied by family/friends; supplied by unpaid volunteers; subsidized by social assistance (Welfare Office); by the Northern Travel Grant Program (where applicable); or by the agency (includes volunteer reimbursement). For more information on transportation and liability issues, please see a copy of this paper and the Order in Council included in Appendix 3.

Timiskaming planners will establish a volunteer network, spread throughout the district and co-ordinated by a central dispatching system.

The issue of transportation has not been resolved to the satisfaction of local planning groups. Timiskaming planners have paid considerable attention to making withdrawal management services more accessible. They identified several transportation options, and decided to develop a co-operative network of volunteers, recruited throughout the district and co-ordinated by a centralized administration and dispatching system. One of the network's goals is to have a 30-minute response time by two volunteers who are on-call at all times (one to drive and one to attend to the client) in each community or designated area of the district.

The planners are considering a variety of ways to motivate the volunteers and support their commitment. Reimbursement by the service was rejected because of bookkeeping and other administrative costs. As well, by reimbursing volunteers for expenses, the service will increase its responsibility and, therefore, its liability. Volunteers will use their own cars and incur all the travel costs but, as far as possible, the planning group intends to use the client's resources and to recover expenses from the client or the client's family.

MONITOR THE CLIENT DURING WITHDRAWAL

Monitoring allows staff and support persons to respond to changes in the client's needs and resources after the assessment.

In order to reduce the possibility of complications during withdrawal, trained staff, volunteers or, in the mildest cases of withdrawal, informed friends or relatives will monitor the client. These people will need to be familiar with the care plan and have enough training to recognize complications and supervise medically recommended procedures.

Monitoring is the ongoing evaluation of the client's physical and psychosocial condition.

Monitoring evaluates the client's response to care by continually assessing his or her physical state. Staff can use standard instruments that quantify physical withdrawal symptoms (the CIWA-Ar, for example) for this purpose. How often a person needs to be monitored will depend on the client's condition, the severity of dependence, the substances involved and which phase of withdrawal the client is experiencing.

Monitoring will allow staff to change the client's care according to these circumstances. For example, the severity of withdrawal from alcohol has a definite path, and will increase and decrease over its course. During the monitoring of alcohol withdrawal, therefore, it is recommended that the CIWA-Ar scale be applied as early as possible, six to eight hours after drinking, for example, and then every one to two hours after that. In cases of mild withdrawal, symptoms may appear a few hours after the client stops drinking and may disappear within 48 hours. In more severe withdrawal, symptoms intensify; seizures may occur between 12 and 48 hours after drinking and delirium tremens 48 to 96 hours after drinking.

However, monitoring also checks the client's psychological state and social circumstances. While the initial assessment develops a care plan that capitalizes on client resources and provides for his or her needs, monitoring verifies that the client is experiencing a safe withdrawal and that the environment continues to be positive and non-threatening. Monitoring allows staff to respond appropriately when (1) the initial assessment was incomplete, (2) the client's resources and needs change over the course of withdrawal, and (3) withdrawal is completed and the client is ready for continuing treatment.

Planners can create monitoring procedures by using the assessment instrument they have developed, including additional guidelines for:

- identifying client needs and resources that were missed during (or have changed since) the assessment
- identifying when withdrawal is complete
- responding appropriately.

Monitoring ends when withdrawal is complete. All changes in care must be documented.

Monitoring will evaluate whether the withdrawal management option selected for the client is working. For example, the assessment may recommend home detox with family monitoring the client, but a volunteer sent to the home may discover that it is not alcohol/drug-free. Sometimes, the option that the client finds acceptable is not the option that will achieve the objectives of the service. Through monitoring, staff can help the client to accept the option that will provide the level of care he or she needs to complete withdrawal. Staff should document all changes in care, or problems identified during monitoring, in order to evaluate and improve the service.

The monitoring procedure can include a checklist of factors that indicate improvement in the client's condition. When withdrawal is finished, the client will feel better physically and will eat and sleep better. Observed and reported withdrawal symptoms will have abated, and the client will be ready to discuss continuing treatment. Tests on urine or blood samples will show that the client's body has eliminated toxic substances.

Staff and volunteers who monitor withdrawal will require special training. Staff at detox centres are trained by the Ontario Detox Directors' Association (ODDA) in co-operation with the Addiction Research Foundation. This course is for staff with

Withdrawal management clients are monitored by trained staff or volunteers and/or an informed client support system.

experience in and knowledge of the addictions field. It provides an in-depth orientation to a number of physical and psychosocial issues in withdrawal management. For more information about this training course, contact the ARF's Training, Education and Development Department, 1-800-661-1111. If you plan to create your own training program, ensure that it includes: how to use standard assessment and monitoring techniques; how to provide appropriate physical and psychosocial support in a variety of situations and for a variety of substances; Cardiopulmonary Resuscitation (CPR) and first aid courses; non-violent crisis intervention techniques; motivational counselling; and ways to link the client to continuing treatment.

Families and other support persons will also require information and basic training when they are monitoring the client at home. For a practical guide, please see David Cooper's book, *Alcohol Home Detoxification and Assessment*, which is included in our bibliography (Appendix 4).

With the proper training, a variety of people will be qualified to monitor the client in a variety of settings – a residential facility, the client's home or during outpatient appointments.

ARRANGE ACCESS TO EMERGENCY MEDICAL SERVICES

Withdrawal management services need to be prepared for medical emergencies and to have procedures in place for initiating emergency medical care.

Careful monitoring means that complications will be identified early and the appropriate measures taken. Emergency medical services may consist of a visit by a physician or nurse, if this service is available. Some complications may require getting the client to a hospital. In this case an ambulance may be used. As discussed in Chapter 5, Assessment (see pages 40-42), clients should be referred to hospital if they experience an urgent medical or psychiatric episode during withdrawal, or if pre-seizure activity, seizures, hallucinations or irregular vital signs (blood pressure and pulse) make withdrawal severe enough that clients should be cared for in a hospital.

ARRANGE FOR MEDICAL MANAGEMENT

Medical management of withdrawal can take place in a variety of settings, provided a physician's assessment has been obtained and someone is available to supervise the client's prescription.

Medication may be required to ensure the safety of the client and to reduce the risk of complications during withdrawal. For clients at high levels of risk, the service will need a physician to complete a full medical assessment and to confirm whether or not medication is required. Withdrawal management staff will be responsible for arranging this medical assessment and helping the client to take prescribed medication. They may need to instruct those providing supportive care, hold the client's medications and remind clients to take them as prescribed, or

arrange for a community nurse to attend the client at home. Staff may also need to apply standard tests for over- or under-sedation, and refer any problems to a physician. Planning these aspects of care will involve local family doctors, nurses and medical facilities. Colin Bennie [51] describes a home detox service in Scotland that is linked with the client's family doctor, who verifies that medical complications (such as seizures) are not expected and prescribes medication if required to manage severe symptoms.

OPTIONS FOR DELIVERING YOUR SERVICE

Consider a variety of withdrawal management settings.

As long as the preceding considerations have been addressed, withdrawal management services can be delivered in a range of settings. Consider the seven service delivery options described below in light of what is available and needed in your community. Remember that a range of options will help the service respond to the needs and resources of different people seeking help.

Option One:
At home, with family or friends providing ongoing monitoring.

Option Two:
At home, with a volunteer providing 24-hour monitoring during physical withdrawal.

Option Three:
At home, with periodic medical supervision, with or without volunteer monitoring.

Option Four:
At a friend's or volunteer's home, with or without periodic medical supervision.

Option Five:
Outpatient/day withdrawal management to which clients travel.

Option Six:
Outpatient/day withdrawal management which travels to clients.

Option Seven:
Residential withdrawal management in a social or medical setting.

In the following section, we will look at each option in turn and try to define which would be appropriate for the different conditions and circumstances of different clients.

We describe seven options for service delivery and provide guidelines which can be explored during service planning.

Based on our experience and the research literature on detoxification, we will provide some guidelines about which circumstances make specific options suitable. Some of the options are not discussed in the literature. We recommend a thorough planning effort to determine which methods are appropriate and feasible for your community before implementing any of the options. In general, the least intensive and intrusive are listed first, and the options become more intensive and intrusive as the list continues; for example, medical management of withdrawal first appears in Option Three.

Option One: At home, with family or friends providing ongoing monitoring

Options One through Four use the home environment to deliver withdrawal management services.

The home is either the client's, a friend's or a volunteer's.

A family doctor and a community nurse co-operate with the service to provide medical management.

Monitoring is based on the client's physical and psychosocial needs.

In this option, supportive care is provided in the client's home by a family member or a friend, who will also bear the main responsibility for monitoring the client's safe withdrawal. This option is appropriate for clients with mild to moderate withdrawal symptoms (for example, a CIWA-Ar score of less than 25). The client must be physically and mentally fit, with no history of seizures or delirium tremens during previous withdrawal attempts. There must be no possibility of violence in the home. The environment should be free of drugs and alcohol, and a responsible adult should be at home for a three to five day period. This adult should be a strong advocate for the client, and preferably abstinent.

Because a friend or family member will carry most of the responsibility for the client, this option requires that a 24-hour crisis intervention service be in place in case unexpected complications arise. At the least, this emergency service might be the current ambulance system; more helpfully, a special hotline for consultation and advice would be a welcome backup for family or friends. In any case, the service should provide the support person with detailed information about what to look for during withdrawal. David Cooper recommends that this information include safety, hygiene, environment, psychology, hydration, eating, drugs, withdrawal fits (seizures), and a contact name and number to obtain further support, advice and counselling.[52]

This option must include periodic monitoring and a continuing treatment plan, so planners will need to address transportation and staffing issues. A volunteer or other trained staff member could be sent within 24 hours to speak with the client and a family member or friend, to conduct the initial assessment and to begin planning for continuing treatment. Withdrawal management staff link the client to outpatient care, self-help groups or other continuing treatment resources in the area, and motivate him or her to continue recovery.

In some cases, resources from other community services may be needed in order to make the home a supportive environment. The volunteer would review the home objectively and make contact with social services as required. For example, because of financial hardship a client's support person may be unable to provide adequate nutrition, heating and basic physical needs. The assessment may or may not have identified this problem; even with careful questioning, family members may not wish to say that they cannot give adequate support. In economically depressed areas, social service agencies may be able to supply the resources that the family needs to meet the service's standards for care. In this way, those homes that want to assist in detoxification can still be used to the advantage of the client and the service.

As part of this option, you could consider giving the client a self-help book such as *Saying When: How to Quit Drinking or Cut Down* by Addiction Research Foundation scientist Martha Sanchez-Craig.[53] This self-help book may assist the client to set goals about their drinking and to maintain progress; it is meant for people who recognize that their drinking is causing problems but who do not want to enter

formal treatment. The author describes its benefits as: "privacy, anonymity, flexibility and a choice of appropriate goals." She also provides this qualification: "Saying When is aimed at early-stage problem drinkers and is not intended for people who are severely alcohol dependent or those who have serious medical, social or personal problems or problems with other drugs."

Option Two: At home, with a volunteer providing 24-hour monitoring during physical withdrawal

Volunteers, when used appropriately, make a cost-effective contribution to service delivery.

This option is similar to Option One and is for clients in similar circumstances, except that a responsible adult is not available for a period of three to five days. These clients may live alone or may not be able to depend on support from a friend or a family member. In this option, a volunteer would be sent to the home immediately, and would monitor the client during withdrawal. The delivery of the service would be the same as described for Option One.

Volunteer recruitment, training, motivation and supervision are the unique considerations for delivering this service. While all withdrawal management staff will require training, not all will be paid. Currently, self-help and support groups monitor people withdrawing from alcohol and drugs on a voluntary basis. In small urban, rural and remote communities, a withdrawal management service will use volunteers as much as possible to monitor clients in a variety of settings. Volunteers can reduce the costs of the service, so your community will probably be interested in recruiting, training and motivating a core group of people.

To help you in this task, a health promotion organization in California has published a practical guide called "Volunteers." This brief booklet is part of a series of *How-To Guides on Community Health Promotion*, and it considers topics such as, drawing up job descriptions, recruiting appropriate people, training them, supervising them, evaluating them and "getting the best out of them." The guide points out an important benefit to recruiting volunteers: "Volunteers have a value beyond their labour. They provide a link between the organization and the community, because they are the community."[54]

While many communities will already have volunteer services, you may need to enlist more people in order to expand or improve your service. We thank the Ontario Detox Directors' Association (ODDA) Executive for the following suggestions about recruiting a core volunteer group:

- Contact professionals in social services, education and health care for assistance in recruiting volunteers.
- Look for unemployed or underemployed professionals in social services, health care or education.

- Look for people who have recently taken Cardiopulmonary Resuscitation (CPR) or first aid courses.
- Use the local media and distribute flyers.
- Promote training as a benefit of involvement.
- Create a backup support system for volunteers.

Option Three: At home with periodic medical supervision, with or without volunteer monitoring

A medical assessment will determine when a client could benefit from medication during withdrawal. Withdrawal management services will arrange for this assessment and for the prescription, which could be issued by the client's family doctor. The service will also arrange periodic monitoring by a suitably trained health care worker, such as a public health nurse. The now discontinued Exeter Home Detox service, which we mentioned in Chapter 5 on page 47, is an example of this option.

Medically managed home detoxification has been implemented in England, Scotland and Australia.

Tim Stockwell originally developed the home detox model as the Exeter Home Detox Project. In this model, the client receives medication for up to seven days under the order of the family doctor, as long as the client abstains from alcohol. A community psychiatric nurse (CPN) offers encouragement and psychological support. He or she also monitors the client periodically for three to 14 days, twice a day for three days and once a day after that, with each visit lasting two or more hours. At each visit, the CPN does the following: (1) checks for over- or under-sedation using a standard checklist, the CPN's and the support person's observations, and the client's report; (2) takes vital signs and consults the general practitioner about any problems; (3) confirms abstinence with a breathalyser test; (4) decides whether or not to stop, increase or decrease medication; and (5) advises and counsels the client and the support person. David Cooper fully describes this model in *Alcohol Home Detoxification and Assessment* (see our bibliography in Appendix 4).

Reports from Scotland and Australia[55] support Stockwell's conclusions:

- In the short-term, home detox is as safe and effective as inpatient hospital care.
- Clients prefer home detox; it is accessible and acceptable to wider range of problem drinkers and their family doctors. Some clients said they would refuse to go to hospital for withdrawal. (Colin Bennie of Scotland reports that 30 per cent of his clients are women, while Ontario's detox centres reported that in 1992-93, 14 per cent of their clients were women.)
- The CPN's support is the most welcome element of care.
- Relatives like the breathalyser test, medication and having telephone access to the CPN.
- The service effectively links clients to continuing treatment. In the Exeter Home Detox Project, for example, 30 of the 33 clients attended a follow-up appointment.

- The service effectively reduces alcohol intake. Two-thirds of the Exeter Home Detox clients reported a reduced alcohol intake at a follow-up appointment two months later.

This service requires a close collaboration with the local medical community. We recommend that you include physicians in the planning process and address them specifically in your service awareness campaign. Keep in mind that family doctors may be encouraged to co-operate when staff provide them with regular reports on their patient's progress and solicit their suggestions for planning and improving the service. Colin Bennie's service in Scotland, for example, enjoys a co-operative relationship with local doctors by using these and other methods to involve them.

Option Four: At a friend's or volunteer's home, with or without periodic medical supervision

Not all client homes will be able to provide a supportive environment, so consider using volunteer homes rather than residential care.

This option may be appropriate for clients who do not have a home or whose home is not free of drugs or alcohol or not supportive of detoxification in some other way. For example, the positive attitude of family and friends in the home is essential to encourage the client to complete withdrawal and seek further treatment. However, it is difficult to overestimate the strain that substance abuse places on relationships. While family members may be supportive at first, their ability to provide a base for recovery will erode over the course of unsuccessful attempts at withdrawal and recovery. If the client has tried detoxification at home without success in the past, his or her family may not be able to offer a positive, non-threatening environment and supportive care. The home may also be unsupportive if the risk of noise and frustration is significant; Colin Bennie's home assessment includes finding out both the attitude of the support person and also whether small children are present.

"Foster homes" situated throughout a region could provide this service. Some self-help groups and First Nations communities currently use this system. In this option, volunteers, who are reimbursed for costs they incur while caring for a client, would be expected to remain on call, open their doors upon request and provide the required amount of monitoring to ensure the client's safety. Because the service reimburses volunteers, planners must deal with liability, contracts and compensation. You will also need to consider procedures for maintaining service standards, the recruitment, training and scheduling of volunteers, and transportation.

For any client who looks after dependants, the service may need to arrange temporary care during withdrawal. The backup services described in Option One (a 24-hour crisis intervention service and detailed information about what to look for during withdrawal) should also be available. When the client needs medical supervision, the service should provide periodic monitoring as described in Option Three.

Foster homes are not the only intermediate place for withdrawal. You could also consider the use of rental units, such as motels.

Option Five: Outpatient/day withdrawal management to which clients travel

Options Five and Six describe outpatient services to which the client travels or which travel to clients.

Run from an existing facility – for example, a health clinic, detox centre, or hospital – this service caters to clients who can travel to it. The service could provide medication (such as chlordiazepoxide or diazepam for withdrawal from alcohol), if the care plan calls for it, and could also be responsible for educational and therapeutic activities to a greater or lesser extent. Staff would monitor clients from time to time to supplement monitoring in the home, and would link them to continuing treatment.

At a minimum, clients would have daily appointments of one or two hours, for up to two weeks. If clients will have to travel long distances (for an hour, for instance), planners could consider establishing a service in a residential facility. This would allow clients to stay in the facility for several hours, up to a day. Volunteers and other staff would monitor and follow up on their progress when clients attended the facility, but clients and their support persons would also monitor the withdrawal at home.

When considering this option, staff will need to assess the home and the client's support system. The family member or friend who is supporting the client will have to provide transportation to and from the facility, and monitor the client at home.

A day detoxification service could be convenient for clients, if one family member works in a small community and drives back and forth daily from home. By supervising the client during the day, the service could allow him or her to stay home as much as possible, while saving on the expense of monitoring the client at home, or providing transportation or 24-hour supportive care.

Outpatient services can be implemented in a variety of ways. We have identified in the literature several models which can be modified for use in delivering withdrawal management services in small communities.

There are several documented examples of outpatient services. One of them, the Maudsley Alcohol Treatment Service, we discussed in Chapter 5, Assessment (see page 48). Another brief outpatient service was implemented in Glasgow, Scotland, for young people with solvent abuse problems.[56] A drop-in centre was set up in a downtown police station. Children and their caregivers stopped in to learn about crime prevention and to receive an assessment and counselling from a psychiatrist. The evaluation of this service showed that only a small number of the children were referred a second time, considered an indication of success. But other experts claim that young people with solvent abuse problems need significantly more help to begin recovery.[57] Because there is not a lot of information to guide community responses to solvent abuse, we recommend that you proceed cautiously. This type of service would aim to support families, to encourage young people to change their behavior, and to identify children who need further treatment.

In Gallup, New Mexico, there is an outpatient service designed for aboriginal people that could apply to any group living in a remote or rural setting. Run out of a residential facility that provides addiction treatment, this clinic tries to attract people coming into town on the weekend to shop.[58] The organizers found a school to house participants who could not afford a motel, and set up a network of people to look after children. Gallup's weekend clinic is a brief intervention treatment service and not a withdrawal management service. However, it inspires ideas for an outpatient option that uses existing treatment facilities. In this type of service, trained staff could monitor and supervise clients on the weekend or in the evening, provide a supportive environment outside the home and link clients to continuing treatment. The aim of this service would be to support the friends, family and volunteers who are taking most of the responsibility for managing withdrawal.

In another outpatient study,[59] detoxification was managed from a psychiatric emergency room, Monday to Friday, nine to five. Staff gave clients a breathalyser test daily and, because this was a research study, terminated treatment if the client had consumed alcohol. Diazepam was dispensed daily, and dosages were adjusted if staff observed or clients reported over- or under-sedation; thiamine was given orally. Five 30-45 minute counselling sessions were provided by the nurse who had made the initial assessment. The first session was an assessment; the second was another assessment, a physical examination and health education; the third was the same as the second, with a discussion of coping strategies; the fourth was the same as the third, with an emphasis on long-term strategies; and in the fifth session, the nurse gave the client feedback about the withdrawal process, discussed long-term support and referred the client to Alcoholics/Narcotics Anonymous or other self-help groups.

Research shows that outpatient services are cheaper and more flexible. Most importantly, medication allows outpatients a safe withdrawal even when severe symptoms are expected.[60] If you are considering this service option, you will want to establish close ties with the local medical community. To encourage family doctors to participate, we suggest making information available about the medical management of withdrawal. Addiction Research Foundation scientists are currently revising a handbook for physicians[61] that describes methods for managing withdrawal with medication. The service could also help family doctors by providing trained staff to monitor clients on medication and by reporting regularly to family doctors on the progress of their patients.

Option Six: Outpatient withdrawal management which travels to clients

In this option, staff would take several weeks of substance-free activities to clients, and co-ordinate the management of withdrawal, as required. One example of this concept is the Saskatchewan Alcohol and Drug Abuse Commission's Mobile Treatment Unit.[62] The MTU provides alcohol- and drug-free social activities and counselling for up to 30 people in their own community during the day and

A mobile withdrawal management service can be modelled upon a mobile treatment unit developed in Saskatchewan.

evening. The service has three phases: orientation and set up in the community (one week), treatment (two to three weeks) and, after a period of time, a return to the community to follow up (one week). In the Nechako Centre Treatment Program,[63] treatment for the first two weeks focuses on the client's issues of self-expression, self-awareness, sharing in the group, taking responsibility for self and problem-solving. The last week of treatment offers a Couple's Program, a Single Parent's Program, and emphasizes communication, interpersonal skills, parenting, community participation and developing a resource network. Time is also provided for exercise, meditation and prayer, and social activities such as movies, square dances and games nights.

The mobile unit idea has been received with skepticism as an alternative service for withdrawal management in Ontario. In part, criticisms stem from this model's emphasis on counselling and social skills; in withdrawal management the emphasis is on monitoring the client and providing supportive care. As well, a mobile unit requires staff to travel, which critics see as inefficient. But this option has suffered the most from the idea that detoxification services must be available on demand to provide crisis intervention. For example, to provide service on demand, a travelling mobile unit serves one or two clients in a single area, and moves to the next community that has requested the service; accordingly, staff travel constantly with little hope of meeting every person's need.

As a co-ordinating team, the mobile unit would use the community's resources to offer options for managing withdrawal.

Despite these criticisms, we believe a mobile unit may be a useful option for planning groups who wish to reach remote areas with no access to service, and who want to engage people in activities that support the completion of withdrawal and the continuation of treatment. The travelling team should be seen as a co-ordinating mechanism that will set up appropriate withdrawal management services in the community for a limited period of time. During the orientation and selection of participants, staff could begin planning for withdrawal management. A network of local families, friends and volunteers, using community resources, can help people to complete withdrawal and select some kind of continuing treatment. The network could also provide supportive care and monitoring, as described in Options One to Four. Planners could add medical care to this model by including a health care professional in the travelling team or linking with the nearest nursing station.

This service could manage withdrawal and plan for continuing treatment by following one of the outpatient models described in Option Five. For example, activities could be held in a variety of local facilities, depending on the activity and community resources. Individual interviews or assessments could be conducted at local offices, health clinics or in clients' homes; groups of clients could meet in class-rooms, churches, community halls or volunteer homes; clients could stay in their own homes, in a local health unit or in temporary facilities such as tents and trailers.

This option would be most effective in communities where a large proportion of people use high levels of alcohol and/or drugs. If you are planning an outreach service for a remote area, you will need to consult community leaders, conduct

a needs assessment and identify local resources in advance. Staffing a mobile unit may be complicated. Your service will probably not be able to spare withdrawal management staff to conduct a three or four week exercise; on the other hand, the mobile unit will not require full-time, permanent staff. Your service might be able to use a social work intern and an experienced volunteer to deliver this kind of service, and make the mobile unit available only during certain periods of the year. Full-time staff could provide the mobile team with back-up expertise over the telephone.

A mobile unit provides outreach to remote areas that do not have access to service. This is one of the objectives of withdrawal management.

In Kingston, Ontario, a mobile detox service is offered by the Hotel Dieu Detox Centre. Staff set up detox services on the Queen's University campus during Frosh Week and when there are home games or other special events. A flyer describes the Campus Observation Room as a "safe, supervised facility" staffed by experienced detox workers and student volunteers. Detox workers volunteer for this assignment and are paid by the university when on duty there.

Option Seven: Residential withdrawal management in a social or medical setting

While many clients can and do complete withdrawal safely in other settings, some people will need residential care for five to 10 days. Residential detoxification, with or without medical supervision, can be made cost-effective if planners use existing facilities in the area, such as a local hospital, addiction treatment agency, detox centre, health clinic or home for seniors. Designating beds in hospitals may be the only option available in a community; however, our discussion of service Options One to Six may spark ideas in your planning group for ways to give supportive care outside of a medical environment.

Based on the data available to us, it is difficult to determine how many clients will require residential care. In part, this is because other forms of managing withdrawal have been largely ignored in Ontario in favour of the urban detox model; therefore, the province has no statistics for the other options. Other countries, however, have been offering a range of withdrawal management services for over a decade. The experience of the Maudsley Alcohol Treatment Service, located in London, England, is that 20 per cent of their clients require inpatient care. Using this experience as a guide, our conclusion is that planning groups need to provide a residential option as part of their withdrawal management service plan.

Up to 20 per cent of withdrawal management clients may need care in a residential setting, such as a detox centre, hospital or addiction treatment facility.

The percentage of people requiring residential care may be different for rural and remote areas and small urban centres. On the one hand, it may be higher than 20 per cent, because travel considerations may make outpatient services less acceptable to clients. On the other hand, good community links and use of the service by individuals with less severe problems may reduce the percentage.

The nature of the substance-use problems in the community and the availability of other service options will have an impact on how many clients need residential care.

The use of designated beds in existing residential facilities will help to reduce the costs of implementing and delivering the service, but will require a strong local commitment to planning.

A small proportion of withdrawal management clients (two to five per cent) will require care in a medical facility because of a concurrent medical condition or because the severity of their withdrawal constitutes a medical emergency. (For more information on the need for inpatient medical treatment, see Chapter 5's discussion of withdrawal assessments.) However, most clients who require a completely protective setting for withdrawal can be cared for outside a medical facility. When a client needs medication to complete withdrawal, for example, planners could consider arranging for daily visits by a physician or community nurse. This would be a cost-effective way to care for clients in a non-medical residential setting.

Because this service option is stationary and will most likely be implemented in small urban communities that serve rural and remote areas, transportation is clearly a major consideration. The service will need the co-operation of the police and the ambulance system to bring clients to the facility. In addition, staffing and training will require careful attention. If you decide to provide this service from designated beds in an existing facility, you can reduce costs by asking the facility's staff to monitor clients periodically or remain on call during slower periods. Keep in mind that residential services raise various administrative issues. Using local residential facilities, for example, will involve legal and contractual considerations. Building a residential setting for withdrawal management will also involve insurance, permits and licences, as well as contracts with services to provide maintenance, laundry, and nutrition.

❧

S U M M A R Y

We have proposed a number of possible ways to serve people who need assistance to withdraw from alcohol and drugs. These options range from minimally intrusive methods, which take a pro-active approach and help moderately dependent people, to intensive methods, which create a completely protective environment for people with very severe problems. The goals of each option should be the same: the client's safety, the client's satisfaction and continuing abstinence, the completion of withdrawal, and contact with continuing treatment.

Ask the following questions to plan for your clients' needs during withdrawal and to explore options for your service. Timiskaming's experience will provide some examples.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. Which facilities in our community could be adapted for withdrawal management services?

2. What are the best surroundings and conditions for people in withdrawal and how can we create them for our clients?

3. How can we transport clients to the service? Who should we approach and what roles would they play?

4. How can we transport the service to the clients?

5. How much time should elapse between a request for help and contact with the client? How will this goal affect our plans for dispatch, staffing and service mobility?

6. How can we address liability issues in transportation?

7. Who will pay for transporting our clients?

8. For each service location, who will monitor our clients?

9. What training will they require?

10. When will monitoring begin and end in our service?

11. Which services in our community can provide emergency medical help?

12. What will be the role of each emergency service?

13. What kinds and degrees of emergency do we expect?

14. Where will medical supervision be provided?

15. How will withdrawal management staff, volunteers and families work together with physicians to give clients medical care?

16. Which options for managing withdrawal are feasible in our community?

17. Which of our clients will best suit each option?

18. In each option, how will we ensure that our standards can be met for delivering physical and psychosocial support?

19. How can we help families and other support persons to be involved?

20. What roles will volunteers play in each of these options?

21. How can we can recruit and retain volunteers in our community?

EXAMPLES FROM TIMISKAMING

In the Timiskaming district, the most feasible options to pursue at this time are designated beds, home and outpatient detox.

Timiskaming planners have identified possible beds for the service throughout Timiskaming. This geographical distribution will improve access. They are negotiating agreements for the withdrawal management service to run designated bed sites in five communities throughout the district. These possible sites include a residential addiction treatment agency, a hospital, a renovated home and two health clinics. Designated beds will be available to men and women. Whenever possible, the client's home will be used.

The planners have decided to use the following transportation methods:

- Family members will be encouraged to bring the client to the service.
- Volunteers will be recruited throughout the district to minimize lengthy travel and work overload, and they will use their own vehicles.
- Taxi companies located in all major towns of the Timiskaming District will be used.
- When necessary, clients will be transported by ambulance.
- When appropriate and when their resources allow it, police will transport clients.

The maximum response time for the Timiskaming District will be 30 minutes. Volunteers will live throughout the district so that all citizens are no more than 30 minutes from help.

In Timiskaming the service will also come to clients. Withdrawal management staff will visit clients, as will trained home care professionals who have been temporarily released from their regular duties to work for the service.

The service plans to reduce liability in several ways: by making the best possible use of private vehicles and by not compensating for travel; by ensuring that a consent to travel is obtained during assessment; by allocating two people to the transportation of each client; by making the transportation plan consistent with the Ministry of Health's policy statement of December, 1992 (see Appendix 3); and by consulting with a lawyer before initiating the program. Staff will also reduce risk by being available to the volunteers for consultation, by ensuring quick response times, by screening and training volunteers, and by arranging for written agreements with taxi companies and other partners in transportation.

At most designated beds, withdrawal management staff will monitor clients. But in health clinics, public health nurses will offer this service, while withdrawal management staff and volunteers provide backup and support. These sites will also supervise outpatient withdrawal. The service will also provide staff for other locations with designated beds (such as senior citizen homes and Salvation Army facilities.)

In private homes, withdrawal management staff and home care providers, temporarily released from their regular duties, will monitor clients. Where appropriate, trained volunteers will provide this support. The method of monitoring withdrawal will be negotiated with clients and their support persons. The service will make as much use as possible of family members, who will be given basic instruction by a professional or trained volunteer, and will be provided with 24-hour backup. The service will also help family members to cope with withdrawal and recovery by offering them support services, referrals to community services, education about addiction, and life skills training. Where appropriate, families will be involved at various stages of the client's progress, from assessment to continuing treatment. In cases of family violence, the service will provide – on request and when the perpetrator is removed – an assessment of the family situation and assistance to family members in withdrawal.

In the Timiskaming district the three hospitals, ambulance services, physicians, health care clinic staff, and North Bay Psychiatric Hospital will all provide emergency medical services. Planners anticipate that medical supervision will take place in hospitals, health care clinics, homes and all other locations designated for service delivery. The service will create continuity in medical supervision by defining the role of each care provider within a team concept. If the client requires medical care, a physician will co-ordinate the team.

Volunteers will play a key role by transporting clients to the service, giving support and information to families and providing backup to professional staff. They will be distributed throughout the district and will work in pairs to reduce their responsibilities and workload. They will receive comprehensive, ongoing training, and their responsibilities will expand as their experience and training increase. The service will encourage them to contribute to program planning, will regularly give recognition to their work, and will create opportunities for social interaction. The Timiskaming planners feel that volunteers will be rewarded by the demonstrated effectiveness of a service that encourages their involvement, provides a non-hierarchical structure and gives them opportunities to achieve professional status.

CHAPTER 7
PLANNING FOR CONTINUING TREATMENT

OBJECTIVE

Impact of Planning for Continuing Treatment

1. Increased number of clients completing withdrawal who enter a treatment or assessment/referral service.

> In the service framework we propose, the following activities will achieve this objective:
> - To have up-to-date knowledge of continuing treatment options;
> - To identify suitable continuing treatment options for every client;
> - To provide each client and his or her support persons with information about options;
> - To assist the client to make contact with services offering continuing treatment by providing or arranging for: transitional requirements, supportive care, transportation, encouragement and follow-up.

When planning withdrawal management services, planning groups must consider how to connect clients with continuing treatment options, both locally and in other parts of the province. The Ministry of Health 1979 *Guidelines for the Planning, Organization and Operation of a Detoxification Unit* stresses this crucial link between detoxification and further addiction treatment:

> It is important that treatment and rehabilitation facilities be available locally before a centre is established... [so that there is an] ...opportunity for residents to enter the treatment/rehabilitation network.

As this statement and the 1992 mandate by the Community Mental Health Branch[64] make clear, one of the primary objectives of detox centres is to link clients to continuing treatment.

Withdrawal management services create clients for continuing treatment; it is therefore important to have continuing treatment options available.

Statistics indicate that detox centres are finding it difficult to achieve this objective. In March 1993, 13 per cent of discharged clients were referred to Alcoholics Anonymous/Narcotics Anonymous, 7 per cent to short-term treatment, five per cent to long-term treatment, four per cent to hospital for medical reasons, and two per cent of discharged clients were referred to the following: hospital for withdrawal management, hostel, outpatient counselling, other agency, and assessment/referral centre. In the same month, a total of 2,180 clients accepted no referral; this figure includes both clients who were not offered a referral because they left the detox centre before a plan for continuing treatment was developed, and clients who did not accept the referrals made by detox centre staff.

DETOX CENTRE STATISTICS (MARCH 1993)

	# of clients	% of discharged clients
Discharged clients	3,714	100%
Clients not receiving/ accepting referrals	2,180	59%
Clients accepting referrals	1,419	38%
Clients with no referral available	115	3%

Linking clients with continuing treatment seems to be problematic. In March, only about 38 per cent of detox centre clients accepted a referral to continuing treatment or other support services. This problem could be due to the waiting periods for short- and long-term residential care. It could also be a result of the lack of outpatient treatment options that are flexible and meet the needs of clients with special concerns, such as women who care for dependants, elderly people who may resist residential care, and young people who benefit from remaining in their usual setting. However, as we do not have complete information about what happens to the clients of detox centres, we cannot be sure. It is disturbing that 115 clients had no referral resources available. Just over half of these clients were in detox centres in Northern Ontario, and close to 85 per cent of them were in detox centres serving small urban and rural communities (Community Care Centre in Barrie, Cornwall Detox in Cornwall, Nipissing Detox in North Bay, Pinegate Detox in Sudbury).

Ensuring access to continuing treatment options will challenge community planning groups in a variety of ways.

Small urban, rural and remote populations have limited access to Ontario's addiction treatment system. Apart from self-help groups, options for continuing treatment may not be locally available for the majority of rural and remote areas. Clients must often travel outside their community for treatment. Clients who wish to preserve anonymity and confidentiality may welcome transfers to a residential program outside the community. However, transfers can also cost the client travel expenses and take the client away from his or her support system. Having treatment away from home can make it harder for the client to develop a network for follow-up after treatment and to achieve a smooth return into the community.

KNOW THE CONTINUING TREATMENT OPTIONS

Planners need to compile a list of continuing treatment options in the early planning stages. This list could become a local directory of services and useful contacts.

The effectiveness of withdrawal management services depends upon the community's resources for providing ongoing treatment. During planning, it is essential to analyze the possible options for longer term client treatment and rehabilitation. In addition to residential care, these options include self-help groups and outpatient counselling as well as services not specific to addiction treatment, such as job skills training and anger management. Planners should identify both local and provincial options for continuing treatment.

During the planning stages, you could create or update a service directory listing local community resources, including the volunteer network. This directory would facilitate the training of staff and volunteers, and would be a useful resource to withdrawal management staff. For up-to-date information about the addiction services available province-wide, staff can contact DART, Ontario's Drug and Alcohol Registry of Treatment, toll-free, at 1-800-565-8603, Monday through Friday from 9 a.m. to 5 p.m. (DART plans to extend its service to the general public in October 1994, and will be open in the evenings until 9 p.m.) The Addiction Research Foundation's *1993 Directory of Alcohol and Drug Treatment Resources in Ontario*, compiled by DART, describes over 200 treatment agencies in Ontario, which are indexed alphabetically, geographically, by treatment type, by services for special populations, and by services in other languages. Listings include location and contact information, hours, clientele, capacity, languages and areas served, disability provisions and other access notes.

IDENTIFY SUITABLE OPTIONS

Withdrawal management staff will approach the client with options for continuing treatment.

Planners will need to consider who will approach clients with options for continuing treatment when withdrawal has been completed. Your staff will establish a relationship with the client during the initial assessment and ongoing monitoring, and will be able to use this relationship to help him or her make choices about continuing treatment. Detox centre staff who monitor withdrawal also identify continuing treatment options, although centres sometimes use a specialized discharge planner. If available locally, assessment/referral centres could be used to develop a treatment plan. However, the low numbers of referrals from detox centres to assessment services raise questions about how useful these services are to detox centre clients. There are issues of practicality and cost-effectiveness, duplication of effort and waiting lists. However, if planners can find ways to work closely with assessment/referral services, this collaboration could create cost-effective and flexible arrangements for assessing a client's continuing treatment needs. For example, Holmes House detox centre in Simcoe and the local assessment and referral service have developed a joint procedure for managing clients and following up with them. Some assessment and referral services may also be willing to meet with clients in their homes, in detox centres or in other facilities.

Identifying options for continuing treatment requires a thorough assessment of long-term needs and resources, and will be most effective when clients and their support persons are actively involved.

Both the client and the client's support person (as appropriate) should be actively involved in selecting options. When staff are developing a plan for a client's continuing treatment, these are some of the important issues:

- history and severity of the alcohol/drug problem
- physical condition
- housing and income
- social support network
- need for specialized psychiatric or psychological care
- the client's responsibilities (work or care of children, for example)
- the client's preferences for continuing treatment (all female or traditional healing approaches, for example)
- language and culture.

Fulfilling this objective of a withdrawal management service requires resources and expertise. We recommend that you draw upon the experience of social workers or discharge planners in residential health care to develop this aspect of your service.

PROVIDE INFORMATION ABOUT TREATMENT OPTIONS

You may wish to provide clients with information about continuing treatment options so that they can make informed choices.

To help clients make informed choices, you may consider displaying pamphlets that describe local treatment services. The Addiction Research Foundation has published an overview of the services available in Ontario for people who need help for alcohol and/or drug problems. This brochure, entitled "Alcohol and Drug Treatment in Ontario," answers some common questions about treatment and briefly reviews the choices available in the province. You may wish to create a small resource centre or to make the local service directory or the provincial 1993 Directory of Alcohol and Drug Treatment Resources available to clients and their families. Withdrawal management staff will provide information about cost, rules, treatment philosophies and activities, and will explain how these aspects of treatment influence its effectiveness. A resource centre could also include up-to-date information for staff, volunteers and clients on alcohol, illicit and prescription drugs and inhalants, addiction and addiction treatment.

The Addiction Research Foundation provides products, information and community consultation to keep Ontario up-to-date on addictions issues. ARF also offers public information materials, products for sale and courses for professional development. ARF area offices (listed in Appendix 5) have samples of these materials and products, as well as product catalogues and staff to support local initiatives in the addictions field. There are 26 area offices that cover the six regions of Ontario.

ASSIST CLIENT CONTACT WITH TREATMENT SERVICES

By assisting clients to make contact with continuing treatment and community services, you can:

- build upon established community links
- encourage client recovery
- discourage relapse.

Planning groups will want to build upon established relationships with local treatment agencies, and to explore co-operative arrangements with agencies outside the community. Ideally, clients should have the chance to speak with people who have used treatment and people who provide it, either over the telephone or after presentations by staff and clients of different treatment centres. Withdrawal management staff could also arrange visits to any facility that a client is considering. For example, Donwood Institute in Toronto holds a free weekly Information Night, at which a video is shown and alumni and staff are present.

Planners may also need to consider which community resources could support clients during a transitional period between the completion of withdrawal and the beginning of continuing treatment. Particularly in rural and remote areas, appropriate continuing treatment may not be immediately available when the client completes detoxification. Contingency plans for these gaps in service might include outpatient services, links to self-help groups, YM/YWCA facilities, Salvation Army, senior citizens complexes, social services assistance for motel accommodation, a church group network of supportive homes, schools, and variations on Options One through Seven (discussed in Chapter Six). Withdrawal management staff may also need to arrange transportation for clients to get to treatment facilities. Community resources such as social services can also help clients to pursue continuing treatment by making arrangements for housing and income, or by taking on some of their responsibilities. For example, day care programs will allow people with children to participate in day treatment.

Creating strong links with these organizations and involving them in your planning sessions will improve your withdrawal management service. Together, you can identify service gaps in your community and find ways to fill those gaps by using resources more effectively or by expanding the options available.

S U M M A R Y

In your planning group, use the following questions to start a discussion of how your service will help clients plan for continuing treatment. The example of Timiskaming planners may serve as a guide.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. What information is available to us about local and provincial addiction services?

2. How should our community's services be catalogued?

3. How can we use the assessment and monitoring of our clients to begin planning for continuing treatment?

4. What are the roles and needs of family members, other support people, and volunteers at this stage of the process?

5. What information would help clients to make informed choices about continuing treatment?

6. How can specific community services provide assistance to our clients?

❧

EXAMPLES FROM TIMISKAMING

The program will create a resource centre that will include the provincial directory developed by the Drug and Alcohol Registry of Treatment (DART), information from other Timiskaming manuals, and a list of other relevant organizations in Timiskaming. This information will be available to clients in a variety of formats: oral, braille, computer-disk, video, print, telephone, fax, sign language, English, French, Cree, Ojibwa.

Planners will develop a procedures manual to help staff: select appropriate continuing treatment options, present and explain options to clients, and help them with the first contact. Staff will learn how to help each client set goals and take positive steps to achieve them.

The service will initiate contact with clients who are at risk of leaving addiction treatment before recovery, and will try to reach an agreement with these clients about the form that follow-up will take. One option is to have clients agree to check in with the service by telephone periodically. Another is to have clients agree that the service will contact them, for up to one year.

Volunteers and allied services will be introduced to this process, and the client's support system will play a significant role in continuing treatment and support.

CHAPTER 8

TAKING THE FINAL STEPS

By answering the questions posed at the end of each chapter, your planning group will have gathered the information that you need to prepare a funding proposal for your service. This information will need to be structured and presented in a clear, succinct manner. Funding sources will be looking to see how you plan to evaluate the implementation and delivery of the service. This chapter briefly considers these two final steps for planning withdrawal management services.

WRITING THE PROPOSAL

There are many resources available to guide proposal writing, whether you are creating a new service or expanding an existing one. Local District Health Councils and area offices of the Addiction Research Foundation are good places to begin. Also, funding sources have specific requirements, so it is best to check those first.

We have taken a basic structure for funding proposals and added the intermediate steps that relate specifically to withdrawal management. Consider the following a checklist for your proposal; it lists the standard content areas. For each item on the list, you may devote a sentence, a paragraph or a detailed section of your proposal.

1. **Project Summary**

2. **Needs Assessment**
   - Define the target group precisely and comprehensively.
   - Describe your community's needs and how they were assessed, including how the target group was involved in the needs assessment.
   - List existing resources, and resources that could be developed by the service.
   - State the rationale for selecting sponsoring organization(s) among key community and provincial partners.

- Provide evidence of links with community and provincial partners.

3. **Goals and Objectives**
   - State measurable outcome objectives.
   - Describe service components and implementation objectives.
   - Include a framework, chart or logic model to summarize the service.

4. **Action Plan**
   - Include an implementation plan and timetable.
   - Provide evidence that the target group is involved in planning and implementation.
   - Describe community development activities and communication strategies for raising service awareness.
   - Identify staff and other elements of care required.
   - Sketch out a strategy for assessing and monitoring clients, and an account of how the most suitable withdrawal management service will be selected for clients with different needs and resources.
   - Demonstrate that your plan will make the service accessible to all segments of the target population, and will include crisis intervention and support to client families.
   - Describe a choice of services aimed at different populations.
   - Offer an account of how a network of community resources, including the self-help community, will be used to deliver the service.
   - Describe the types of training that staff, referral sources and volunteers will undergo.
   - State how medical assessments and emergency medical care will be obtained for clients.
   - Demonstrate that options for continuing treatment exist.
   - Describe how planning for continuing treatment will be undertaken with the client.

5. **Monitoring and Evaluation**
   - Describe your strategy for monitoring the planning and implementation of your service, and list the kinds of data you will collect to monitor the service.
   - Give an account of the methods you will use in your evaluation, including a description of how you will measure outcomes.
   - Describe how you will share the evaluation results with community and provincial partners, with service providers and staff, and with other interested people and organizations.

6. **Funding Support**
   - Demonstrate that alternative funding sources are being or have been approached.
   - Describe plans for ongoing funding after the initial grant.
   - Explain in detail the budget requirements for planning, implementation and maintenance of the service.

PLANNING THE EVALUATION

Minimally, your evaluation plan will include the setting of outcome objectives and the monitoring of outcomes.

Evaluating your service allows you to measure your achievements, identify areas needing improvement and make ongoing adjustments. Evaluation encompasses a wide range of activities concerning the assumptions, objectives, implementation and outcomes of the service. Some of these activities are complex, expensive, and beyond the scope of community planning groups. However, your planning group should expect to set clear and realistic objectives for your service, and should arrange to monitor service delivery (implementation) and the progress of your clients (outcome). The main purpose of evaluating your service is to demonstrate that it accomplished what it set out to achieve.

A management information system can help with evaluation.

An important part of evaluation is collecting information. You should plan to document different aspects of the service, such as the types of clients served, the services provided, and the immediate outcomes of these services. The chart on page 25 will guide you. It indicates the kinds of data which could be collected (outputs). Planners may choose to set up a computer system (a management information system) to record the important data about the clients and the service, such as age, gender, source of referral, time of referral, status at admission, and accommodation. At present, the Addiction Research Foundation is working with treatment agencies to develop an information system for addiction services and this will, hopefully, document all of the basic evaluative information required by funding ministries, boards and others with special interest in withdrawal management and other services. The system is called CBIS, Client-Based Information System.

Your evaluation plan could also look at how the service is delivered. For example, you might need to document how long it takes to get a volunteer to a client's home, the number and nature of complications occurring during withdrawal, or how many clients changed settings during withdrawal. To document the delivery of your service awareness campaign, your group could record the different audiences you wanted to reach, how many were in fact reached, and the number of referrals the service is receiving from each audience. The chart on page 25 provides further examples of the information you might want to collect about service delivery.

Demonstrating the accomplishments of your service will be a feature of your evaluation plan. For example, when analyzing the information you have collected about your service awareness campaign, you may want to compare the number of referrals received from each audience before and after the campaign to see if they increased. Another way to evaluate the results of your efforts would be to see if referral sources are better able to identify candidates for your service after the campaign.

The evaluation plan should also allow you to show that the condition of your clients is improved in different ways. To document this outcome of the service, staff could record each client's continuing treatment plan and arrange to follow up with some or all of your clients. This follow-up could include questions about whether clients followed through with the original plan, whether they were satisfied with your

service, and whether their alcohol or other drug use has decreased. Also, as our framework indicates, an effective withdrawal management service will reduce the use of other services and settings for withdrawal. Your evaluation could include a study of admitting patterns to local hospitals and jails, to see if fewer people are withdrawing from alcohol or drugs in these settings since your service was implemented.

Staff and clients should be involved in making the service more effective and efficient.

As part of an evaluation plan, you could describe how you will identify opportunities to make your service more effective and efficient. This kind of ongoing evaluation is sometimes called Continuous Quality Improvement (CQI), and involves periodic reviews of your service. Staff at all levels, volunteers and clients should be involved in these reviews: (1) to identify the service's most important structures, functions and outcomes; (2) to select appropriate performance indicators and criteria for acceptable performance; (3) to collect and analyze the relevant data; and (4) to create an action plan to improve any deficiencies in performance. Funders may look for both kinds of plans: first, a plan for showing that your service is delivering what it promised, and, second, a plan for showing that the service will be reviewed periodically and improved.

There are many different methods used to evaluate services. They include questionnaires, surveys, interviews, focus groups, and collecting statistics on different aspects of the service. Methods of analysis are also various. One of the recommended methods is to make comparisons between the information collected before and after the service was implemented. Data analysis is quite complex, and we recommend that you consult with experts, such as research scientists, statisticians, and epidemiologists when you have an idea of how you wish to proceed in your evaluation. This consultation will help you to create a plan that makes use of available technology and statistical theory. Without this kind of help, the data you collect for your evaluation may not be able to demonstrate what you hope to prove. For example, experts will help you to decide how many clients need to be interviewed to get a representative sample of your clients. The Addiction Research Foundation provides this kind of consultation.

The Addiction Research Foundation recently published *The Evaluation Casebook*, which is a guidebook to help people improve the quality of their services through evaluation.[65] One chapter is devoted to detox needs assessment and evaluation, including issues such as access to service, client characteristics, and measuring the impact of the service on rates of referrals to continuing treatment and readmission rates. This casebook can be obtained by contacting the ARF.

S U M M A R Y

Ask the following questions in your planning group to complete the outline of your funding proposal and to plan your evaluation. The example of Timiskaming may serve as a guide.

QUESTIONS TO ASK IN YOUR PLANNING GROUP

1. **How many dedicated withdrawal management staff does the service require? What are the roles of each staff member? Where will each be located?**

2. **What organizational structure should we choose for our service, and what are the lines of accountability?**

3. **What will it cost to start up and to maintain the service?**

4. What are the local sources for funding?

5. What portion of our budget should be requested from the provincial government?

6. What methods should we use to monitor the delivery of the service?

7. What methods should we use to monitor the results of the service?

EXAMPLES FROM TIMISKAMING

The Timiskaming planners are considering the following staff, who will be based in different communities throughout the Timiskaming District.

- One **Co-ordinator**: to organize the delivery of service and its integration with community services; to promote the service to key players in the community; to develop and implement internal and community education; to assist in managing withdrawal.
- Four **Case Managers**: to assess and manage withdrawal; to make referrals to community services and to identify options for continuing treatment; to educate and support families; to use training and promotion techniques to increase the community's capacity for managing withdrawal and offering services to clients.
- One **Administrative Assistant**: to provide administrative support to the Co-ordinator and Case Managers; and to support the development and delivery of the service.
- Fifteen **Volunteers** to: transport clients; manage withdrawal: support families; introduce clients to self-help; identify emergency medical situations; assist contact with continuing treatment options; promote awareness in the community; recruit other volunteers; and assist with training.

In addition to collecting the required data on clients, Timiskaming planners will also compare demands for hospital and police services related to withdrawal before and after service implementation. They will also compare potential referral sources targeted and reached, and potential target groups targeted and reached.

The effectiveness of the service will be monitored through an advisory committee and an alliance of organizations and consumers. In addition, (1) the Ministry of Health's evaluation system will be used; (2) regular focus groups will be conducted throughout the Timiskaming District with community partners, including former clients and their families; and (3) staff will conduct ongoing social research to measure the service's effectiveness and to identify emerging issues. These issues will be discussed at all levels: staff, administration, board and alliance.

The service will conduct and record intake interviews, monitor drug withdrawal and collect the required information about the client. In addition, it will trace the client's and the family's progress, by interviewing them at discharge and following up with them later on. A variety of service staff will administer questionnaires designed to trace progress, identify additional needs and determine levels of satisfaction with the service. Staff will contact clients, families, significant others, and referral sources and destinations for the evaluation, and will review any reports on crisis incidents and the outcomes of emergency referrals.

The alliance of organizations and consumers involved in service planning and delivery will create another context for reviewing the service's effectiveness with clients and families. The planning group is considering ways to involve the alliance in evaluation.

Timiskaming planners have drafted the following outcome criteria for each objective, which will be measured in part by the methods described above.

Program Objectives

1. To increase the number of people referred to specialized alcohol/drug withdrawal management and related services:
   - increased number of sources and sectors referring clients to the service
   - increased use of the service by potential client populations
   - increased responsiveness to the changing needs and resources of clients
   - improved planning for health recovery and promotion in the community
   - reduced gaps in service for people with alcohol/drug problems.
2. To reduce the incidence of disruption in families and the community caused by substance abuse:
   - reduced police charges and jail stays due to intoxication
   - reduced complications arising during withdrawal in designated community beds and at home
   - increased compliance with recommended medical procedures.
3. To reduce the cost per person of withdrawal management services:
   - reduced emergency department admissions for people who are intoxicated
   - reduced incidence of clients who relapse, as identified in community agencies and in the withdrawal management service
   - increased number of clients who enter a continuing treatment or support program.
4. To increase the number of professionals, volunteers and planners throughout Timiskaming who provide withdrawal-related services:
   - recruitment of the required number of volunteers in each population centre
   - completion of training as indicated in the service plan
   - increased involvement of existing services in Timiskaming for managing withdrawal
   - establishment of an alliance of organizations and consumers that will conduct systematic planning in both health recovery and health promotion.

Client Objectives

1. To increase the number of people completing alcohol/drug withdrawal in a safe, non-threatening environment:
   - increased number of clients who complete withdrawal in an appropriate, cost-effective setting
   - increased number of clients withdrawing in the home.
2. To increase the number of people who participate actively in the development of their care plans:
   - increased number of care plans that are acceptable to clients and families
   - increased number of care plans initiated with the client's and the family's involvement
   - increased responsiveness of the service to changing client/family needs and resources.

3. To increase the number of clients who establish links with continuing treatment:
   - increased number of clients and families having access to appropriate services
   - decreased incidence (over an extended time period) of contacts with community services and clients that are initiated by withdrawal management services
   - increased incidence of contacts with community services being initiated by clients and families.
4. To increase the number of clients who participate actively in continuing treatment and support:
   - increased number of community services willing to perform case management and support after withdrawal
   - increased number of clients and families completing continuing treatment
   - increased number of clients and families participating in continuing support programs.

CHAPTER 9
CHALLENGES FOR THE FUTURE

In this planning guide, we have addressed issues for planning withdrawal management services in Ontario's rural and remote areas and small urban centres by: (1) identifying the first and final steps for consideration by community groups putting together a service plan; (2) reviewing key issues in withdrawal management, such as target population and service objectives; and, (3) proposing a service framework illustrated with practical examples from a variety of sources.

We have presented a framework for planning a comprehensive service that includes four integrated components – Service Awareness, Assessment, Managing Withdrawal, and Planning for Continuing Treatment. This framework will challenge planners who are improving existing withdrawal management services as well as those who are implementing new services. The Timiskaming Detoxification Planning Committee has tested this framework, and we have incorporated some of its experiences into this guide. There are further challenges ahead.

We offer the guide both to support and to challenge the work of community planners, the Ontario Ministry of Health, the Addiction Research Foundation (ARF), and the Ontario Detox Directors' Association (ODDA). We have aimed at a balanced consideration of the issues that each group faces, with a focus on information for community planners. This chapter will set out our challenges to each of these groups, and will review the ways in which this guide will support their work.

TO COMMUNITY PLANNING GROUPS

It falls to local planners to identify the needs of underserviced populations in their community, to develop responses that will address those needs, and to ensure that the service implemented is both responsive and cost-effective. To help planners in these tasks, we have:

- Identified four possible groups to be served by withdrawal management services. Planners can prioritize these groups and customize them to include people who have been underserved in the past, such as youth, women, and other people with unique needs.
- Described options for delivering service that can be tailored to local resources and circumstances.
- Presented seven alternatives, covering the range of circumstances in which people with problems find themselves.
- Promoted a framework that emphasizes training and the use of existing resources to build services that are cost-effective in the long run.

Because community planning groups will bear most of the responsibility for developing the services we have recommended, we believe that provincial organizations should be prepared to support them. We have included our challenges to provincial groups in this guide. By dividing up all the work to be accomplished, each group will be able to focus on what it does best. Perhaps the complementary efforts of provincial groups and community groups, when followed by an exchange of results, can result in co-ordinated progress.

TO THE ONTARIO MINISTRY OF HEALTH

We have developed a response to The Phillips Group of Companies *Report on the Operational Review of [the] Ontario Detoxication Program.* This planning guide promotes a variety of options for delivering service because we believe that no single model is appropriate for every small community in Ontario.

We have supported the Ministry's initiative to encourage community planning. The guide is based on the principle that the design and implementation of services is best accomplished by local planners, health care and social service professionals, and citizens, including the volunteer sector. Such planning groups build on local knowledge, encourage acceptance of the service and ensure efficient operation. They are also more likely to integrate withdrawal management services with existing resources in the community, and to meet the need for new services as required.

This guide challenges local planners to build better services that are less expensive in the long run by training existing professionals and volunteers, using existing support systems, and delivering less intrusive services to people with fewer problems. However, we believe that local planning groups will need support in order to meet these challenges.

Recognizing that the urban model cannot be replicated in smaller communities, we challenge the Ontario Ministry of Health, through the District Health Councils, to solicit funding proposals for alternative methods of delivering withdrawal

management (such as the service being developed in Timiskaming). Planning groups will also need funding to assess the needs of their community. They may require further financial support, for travel (particularly in remote regions of Ontario) and administrative costs, as they develop their service plans.

TO THE ADDICTION RESEARCH FOUNDATION (ARF)

In working with communities and government, the ARF builds the necessary support by providing knowledge and a forum for exchanging ideas. We have provided a framework that community coalitions can transform into usable and practical methods of delivering withdrawal management services. The Community Programs Department of the Foundation, in partnership with representatives from local District Health Councils and the Ontario Detox Directors' Association, can provide leadership and support for local communities in this task. We challenge the ARF to continue its commitment to developing withdrawal management services that will work in small Ontario communities.

In addition, the ARF provides leadership in research. In this guide, we have identified two priorities for research. The first concerns the development of assessment instruments to support and inform a variety of withdrawal management strategies and procedures. The second concerns the evaluation of innovative models of service delivery.

Developing and testing assessment instruments and procedures for withdrawal management

This guide has identified several options for delivering withdrawal management services. However, in some cases the best way to manage withdrawal will depend to a large extent on how severely the client is intoxicated and how likely it is that complications will require medical interventions. Assessment instruments and procedures have been developed, but their use is limited to situations in which trained assessors have direct contact with clients. Assessments that could be conducted by telephone and involve observations made by untrained observers have received little attention from researchers. The ARF should thus give priority to the development and testing of such assessment instruments. It should also give priority to research concerning the appropriateness of existing instruments such as the CIWA-Ar and the SADQ in social setting detoxification centres.

Assessment instruments ideal for withdrawal management services in small urban and rural communities would, at the least, have the following characteristics:

- be sensitive to signs of intoxication from alcohol, other drugs and alcohol/drug combinations
- be usable in telephone assessments involving intoxicated persons or support persons such as family members
- be highly effective in identifying cases requiring medical attention.

Researchers and service staff should work together to develop and test these instruments. The initiative lead by ARF scientist Helen Annis represents a first step along the lines that we propose.

Studies of innovative withdrawal management programs

The second priority for research addresses a gap in our knowledge about the delivery of withdrawal management services. For the most part, the alternative services identified in this report have not been evaluated in a Canadian context. Therefore, evaluation plans should be included in proposals for new services. Where possible, they should either compare the clients using different service options or compare clients of the service with people who are not receiving service. We also recommend that the plans specify how service implementation will be evaluated and focus on the ways that the success of the service will be demonstrated. However, at a minimum, evaluations of innovative services should include the following:

- A detailed description of the history and context of the new service and the objective needs that gave rise to its development.
- A critical appraisal of the basic assumptions of the proposed withdrawal management service.
- A description of the cases served, including, but not limited to, referral source and other circumstances of referral, socio-demographic characteristics, previous withdrawal experiences, substances used prior to referral, level of intoxication and severity of withdrawal.
- A description of the services provided, including, but not limited to, characteristics of service staff, type and amount of service provided, medications prescribed, referrals to and use of other services during the withdrawal process.
- An account of the short-term outcomes of the service, including, but not limited to, circumstances of discharge, level of intoxication at discharge and referrals to other services.
- Feedback from clients and significant others concerning their level of satisfaction with the services provided.
- Evidence that the service has reduced the use of hospital beds and police cells for detoxification or has otherwise made a positive contribution to other specific problems identified in the assessment of local needs.
- An account of the overall costs of the new service, estimates of the cost per case served and, where possible, evidence that the service is cost-effective.

We have strongly recommended to planners that they consult with professional researchers in the development and implementation of evaluations, and have suggested that they use the ARF as a resource. Therefore, we challenge the ARF to maintain and expand its commitment to the evaluation of programs and services related to withdrawal management.

TO THE ONTARIO DETOX DIRECTORS' ASSOCIATION (ODDA)

The guide was conceived as an experiment in "interactive" report writing that will ultimately be reshaped by the ideas and experiences of groups and individuals across the province. We have tried to design this planning guide to encourage the exchange of ideas. In Appendix 5, we have begun a mailing list of key contacts for the planning of withdrawal management, which includes the directors of detox centres in Ontario. We hope that this list will encourage people to update this guide regularly with examples, suggestions, new literature, and proposals for service that could benefit other groups. The objective is to ensure that those with experience can help those who are learning about this vital area of health recovery.

The ODDA is uniquely positioned to act as a clearing house of information about withdrawal management, to participate and support the planning and implementation of innovative approaches by planners in small communities, and to provide leadership in training initiatives. We challenge the ODDA to maintain and expand its efforts to provide responsive service to the people of Ontario by developing an information network for withdrawal management services.

ENDNOTES

1. In 1984, Michael Gavin and Donald Morgan of the Addiction Research Foundation wrote the *Results of Rural Detox Workshop* (Toronto: Addiction Research Foundation), which travelled much of the conceptual ground covered in this paper.

2. (1) Gerry Cooper, Nancy Huneault, and Kathryn Irwin-Seguin, *Planning for Detoxification Services in Urban and Rural Northern Ontario Communities: A Case Study* (Community Services Division, Addiction Research Foundation, Toronto: ARF Internal Document No. 89, 1987).
(2) Proposal submitted to Health Innovation Fund in the spring of 1989 (rejected).
(3) Proposal resubmitted to Health Innovation Fund in September of 1989 (rejected).
(4) Proposal revised, expanded and resubmitted to Health Innovation Fund in the summer of 1990 (rejected).

   The case has been the subject of local news. On October 23, 1991, both *The Manitoulin Recorder* and *The Manitoulin Expositor* ran stories on the issue. More recently on February 17, 1993, *The Manitoulin Expositor* ran the headline, **Detox centre could be part of renovated MHC**, which ended with the following quote: "While calls for a detox centre on Manitoulin have been unanswered for years, "it is not a dead issue," says Mr. Cunningham [executive director of the Manitoulin Health Centre]."

3. In 1988, the York planning group submitted a proposal to establish a detox centre. The Ministry of Health's response was not favorable and the group began to explore other ways to provide service. The York planning group has changed membership several times in the intervening years. The following group has been meeting since 1993: Addiction Services for York Region; Addiction Research Foundation; Community Substance Abuse Centre; York Central Hospital Mental Health Clinic; York Regional Police Department Community Services Unit.

4. John Zarebski, Doug Bullock, Gerry Cooper, Mike DeVillaer, *Analysis of Addiction Treatment Needs Assessments Published by District Health Councils Between 1989 and 1992* (Toronto: Addiction Research Foundation, 1993).

5. G. Martin, L. Bell, L. Charette, J. Doyle, E. Goladberg, G. Lowery, B. Pedersen, D. Pierson, B. Rush, W. Smith, and E. Stasiak, *Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's.* Final Report of the Advisory Committee on Drug Treatment, Ontario Provincial Anti-Drug Strategy(1990): Recommendation XVII.

6. For evidence that the neglect of rural concerns in health and allied health care is not a phenomenon restricted to Ontario, please see Ian S. Watt, Anthony J. Franks, Trevor A. Sheldon, Rural health and health care: Unjustifiably neglected in Britain, *British Medical Journal,* Vol. 306 (22 May 1993):1358-1359, and Carl G. Leukefeld, Richard R. Clayton and Jo Ann Myers, Rural drug and alcohol treatment, *Drugs and Society,* Vol. 7(1/2) (1992):95-116.

7. The Ontario Ministry of Health, *Partners in Action: Ontario's Substance Abuse Strategy* (Toronto: Queen's Printer for Ontario, 1993).

8. Martin et al., *Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's* (1990).

9. The Ontario Ministry of Health, *Partners in Action: Ontario's Substance Abuse Strategy*:9.

10. The description which follows is inspired by the work of William L. Watt, with Sarah J. Saunders, C. Douglas Chaudron and Terry Soden, *Detox in Ontario* (Toronto: Addiction Research Foundation, 1988).

11. Detox centres do not employ medical professionals and, therefore, do not provide medical management of withdrawal. Hospitals provide emergency medical services when required by detox centre clients.

12. In 1988, the Addiction Research Foundation developed a 40 minute videotape on this theme, entitled "And the Door Was Opened," as a training tool for detox centre staff. This video is available through ARF Marketing at 1-800-661-1111.

13. "When Ontario wanted an alternative to jail for so-called "chronic drunkenness offenders," the Foundation pioneered and pilot-tested a new model of non-medical detoxification. Since then, we've helped establish close to 30 such centres across the province." ARF *From Knowledge to Action: The Addiction Research Foundation at Work* (information brochure).

14. Helen Annis, Norman Giesbrecht, Alan Ogborne and Reginald Smart, *Task Force II Report on the Operation and Effectiveness of the Ontario Detoxication System* (Toronto: Addiction Research Foundation of Ontario, 1976): 25.

15. Alan C. Ogborne and Bhushan M. Kapur, Drug use among a sample of males admitted to an alcohol detoxication centre, *Alcoholism: Clinical and Experimental Research* 11(2) (1987):183-185.

    Alan C. Ogborne, Bhushan M. Kapur and Brenda Newton-Taylor, Characteristics of drug users admitted to alcohol detoxication centres, *American Journal of Drug and Alcohol Abuse* 18(2) (1992):177-186.

16. Michael DeVillaer, *Data from Substance Abuse Monitor, 1992-93.* (Addiction Research Foundation: Personal communication, September 6, 1994) (database).

    This figure of 32 per cent is probably low. A study by Alan Ogborne compared self-report to the results of urine analysis (see endnote 15) and showed that people in detox centres do not always report multiple drug use even when asked. Note that this figure includes prescription and illegal drugs, but not tobacco.

17. Helen Annis, Norman Giesbrecht, Alan Ogborne and Reginald Smart, *Task Force II Report on the Operation and Effectiveness of the Ontario Detoxication System* (Toronto: Addiction Research Foundation, 1976).

Mike DeVillaer and Maria Barbieri, Substance Abuse Treatment in Hamilton-Wentworth: Program Types and Client Characteristics 1991-92, *Substance Abuse Monitor* (Hamilton: Addiction Research Foundation, 1993) (database). The Hamilton-Wentworth information system records that 75% of detox centre clients have access to a supportive person.

18. Based on Brian Rush and Suzanne Tyas, *Alcohol and Other Drug Services in Ontario: Results of a Provincial Survey, 1989* (Toronto: Addiction Research Foundation, 1990).

19. The difficulty Ontario has in serving the hard-to-reach is not isolated to this province, nor to the field of addictions. A brief but thorough argument for health care reform in America focuses directly on delivering care to the underserved: Philip R. Lee, From the Assistant Secretary for Health, US Public Health Service, *Journal of the American Medical Association,* 270(23) (December 1993):2784. This article is of particular interest because it clearly connects policy and results in health and mental health care, and supports the community planned approach that we promote in this guide.

20. *Report on the Operational Review of [the] Ontario Detoxication Program* (1990). Conducted by The Phillips Group of Companies for the Ontario Ministry of Health. Section 3.4.5, Recommendation 3:48.

21. M. Grant and R. Hodgson, eds., *Responding to drug and alcohol problems in the community: A manual for primary health care workers, with guidelines for trainers* (Geneva: World Health Organization, 1991). See Chapter 3: Organizing primary health care services to combat drug and alcohol abuse, and Chapter 4: Mobilizing the community to reduce drug and alcohol abuse.

    See also:

    Tim Stockwell and Sue Clement, eds., *Helping the Problem Drinker: New Initiatives in Community Care* (New York/Sydney: Croom Helm, 1987). Chapter 6: Sue Clement, The Salford experiment: an account of the community alcohol team approach, 121-144; Chapter 7: Terence Spratley, Consultancy as part of community alcohol team (CAT) work, 145-157; Stephen Baldwin, Old wine in old bottles: why community alcohol teams will not work, 158-171.

    Robin Davidson, Alcohol problems research 16. Northern Ireland, *British Journal of Addiction* 86 (1991):829-835. He describes the role of CATs: early identification, community detoxification and peripatetic clinical services.

22. *Broadening the Base of Treatment for Alcohol Problems.* Report of a Study by a Committee of the U.S. Institute of Medicine's Division of Mental Health and Behavioral Medicine (Washington, DC: National Academy Press, 1990).

23. This model for estimating required service capacity was used in the 1988 Ministry of Health document, *A Framework for the Response to Alcohol and Drug Problems in Ontario.* Most recently, the model was discussed in Brian Rush, A systems approach to estimating the required capacity of alcohol treatment services, *British Journal of Addiction* 85 (1990):49-59.

24. For example, detox centres were established in small urban/rural communities like Kingston and Sault Ste. Marie, where the Ontario Ministry of Health's original funding criteria of 1,000 drunkenness arrests per annum was not met. See Alan C. Ogborne, Manuella Adrian, Brenda Newton-Taylor and Robert Williams, Long-term trends in male drunkenness arrests in Metropolitan Toronto: effects of social-setting detoxication centres, *American Journal of Drug and Alcohol Abuse,* 17(2) (1991):187-197. And also see Michael Gavin, Peter Bohm, Robert Carpen, Michael DeVillaer, William Hayden, Alan Ogborne and Dennis Walker, *Final Report of the Treatment Services Coordinating and Advisory Committee, Detox Working Group,* Addiction Research Foundation Internal

Document No. 87, (1987):21. In the 1979 *Guidelines for the Planning, Organization and Operation of a Detoxification Unit*, the most current tool offered by the Ontario Ministry of Health, it is stated that planners can expect 1.3 to 3.5 admissions per 1,000 population. However, the expanded target population defined by the new mandate for detox centres is not included in this estimate.

25. Bob Williams, Kit Chang and Minh Van Truong, *Ontario Profile, Alcohol & Other Drugs, 1992* (Toronto: Drug Addiction Research Foundation, 1992).

26. Dennis Bernardi and Betty Findlay, *The Provision of Detoxification in Timiskaming: A Needs Study* (Timmins Area Office: Addiction Research Foundation, October 1990).

27. M. Grant and R. Hodgson, eds., *Responding to drug and alcohol problems in the community: A manual for primary health care workers, with guidelines for trainers* (Geneva: World Health Organization, 1991):56.

28. Brian R. Rush and Alan C. Ogborne, Program logic models: expanding their role and structure for program planning and evaluation, *The Canadian Journal of Program Evaluation* 6(2) (1991):93-105.

    Alan C. Ogborne and Brian R. Rush, Program logic models: tools for program planning and evaluation, *Strategic Management and Program Evaluation for the Healthcare Administrator*, Joseph Lloyd-Jones (ed.), in press.

29. This guide was published in 1991 by the Health Promotion Branch of the Ontario Ministry of Health. Many of the principles are based upon a U.S. publication: Elaine Bratic Arkin, *Making Health Communication Programs Work: A Planner's Guide* (Bethesda, MD: U.S. Department of Health and Human Services, Public Health Service, National Institute of Health, Office of Cancer Communications, National Cancer Institute, 1989).

30. Please refer to Appendix 1 for detox centre statistics. Note that the number of actual hospital admissions can be lower than the number of referrals to hospital. This can happen for a number of reasons. The service to clients of both hospitals and detox centres might be improved by critically reviewing what happens when those who are referred to hospital are not admitted.

31. Please refer to Appendix 1 for detox centre statistics.

32. One study found that blood pressure did not correlate with severity of withdrawal; pulse, however, did have a significant correlation. John T. Sullivan, Kathy Sykora, Joyce Schneiderman, Claudio A. Naranjo and Edward M. Sellers, Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar), *British Journal of Addiction* 84 (1989):1353-1357.

33. Nabila N. Beshai, Providing cost efficient detoxification services to alcoholic patients, *Public Health Reports*, 105(5) (1990):475-481;480.

34. Marcus Webb and Antony Unwin, The outcome of outpatient withdrawal from alcohol, *British Journal of Addiction* 83 (1988):929-934.

35. This scale was developed by Tim Stockwell and others, and has been used in a variety of studies as a means of quantifying dependence severity. It will be described below under the heading *Standardizing Assessments*, and is included in Appendix 2.

36. The *Final Report of the Treatment Services Coordinating and Advisory Committee, Detox Working Group* (1987), the *Report on the Operational Review of Ontario Detoxification Program* (1990), and the *Ontario Detoxification Program Service Implementation Plan* (1992), all refer to this issue.

37. K. Graham, B. Price, P. Brett, A. Baker, C. Bois, B. Boyle, L. Chapman, M. Eliany, J. Gaskin, G. Martin, L. Sobell, and J. Thompson, *Directory of Client Outcome Measures for Addictions Treatment Programs* (Toronto: Addiction Research Foundation, 1993).

38. D. Raistrick, G. Dunbar and R. Davidson, Development of a questionnaire to measure alcohol dependence, *British Journal of Addiction* 78 (1983):89-95.

39. K.W. Wanberg, J.L. Horn and F. M. Foster, A differential assessment model of alcoholism: The scales of the Alcohol Use Inventory, *Journal of Studies on Alcohol* 38 (1977):512-543.

40. Beshai, Providing cost efficient detoxification services to alcoholic patients, *Public Health Reports*, see endnote 33.

41. The Severity of Alcohol Dependence Questionnaire-SADQ (Stockwell et al., 1979, 1983), which is reviewed by Dr. Beshai, was developed for the Exeter Home Detox program and is currently used in other home detox services (see endnote 44). The scale was also used by Webb and Unwin (see endnote 34), in their study of the outcome of outpatient withdrawal.

42. However, there are scales for assessing drug withdrawal, some of which are the result of modifying scales for assessing alcohol withdrawal. To begin study in this complex area, readers may wish to refer to these articles:

    Andrew C. Churchill, Philip M. Burgess, John Pead and Tony Gill, Measurement of the severity of amphetamine dependence, *Addiction* 88 (1993):1335-1340.

    K. Bryant, B. Rounsaville and T. Babor, Coherence of the dependence syndrome in cocaine users, *British Journal of Addiction* 86 (1991):1299-1310.

    P. M. Burgess, A. M. Stripp, J. Pead and C. P. Holman, Severity of opiate dependence in an Australian sample; further validation of the SODQ, *British Journal of Addiction* 84 (1989):1451-1459.

43. Claudio A. Naranjo and Edward M. Sellers, Clinical assessment and pharmacotherapy of the alcohol withdrawal syndrome, Chapter 12 of *Recent Development in Alcoholism* 4, ed. Marc Galanter (New York: Plenum Publishing Corporation, 1986):265-281.

    John T. Sullivan, Kathy Sykora, Joyce Schneiderman, Claudio A. Naranjo and Edward M. Sellers, Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar), *British Journal of Addiction* 84 (1989):1353-1357.

    John T. Sullivan, Robert M. Swift and David C. Lewis, Benzodiazepine requirements during alcohol withdrawal syndrome: clinical implications of using a standardized withdrawal scale, *Journal of Clinical Psychopharmacology* 11(5) (1991):291-295.

    Edward M. Sellers, John T. Sullivan, Gail Somer, and Kathy Sykora, Characterization of DSM-III-R criteria for uncomplicated alcohol withdrawal provides an empirical basis for DSM-IV, *Archives of General Psychiatry* 48(5) (1991):442-447.

44. Tim Stockwell, Ray Hodgson, Griffith Edwards, Colin Taylor and Howard Rankin, The development of a questionnaire to measure severity of alcohol dependence, *British Journal of Addiction* 74 (1979):79-87.

    Tim Stockwell, Denis Murphy and Ray Hodgson, The Severity of Alcohol Dependence Questionnaire: its use, reliability and validity, *British Journal of Addiction* 78 (1983):145-155.

45. A series of three Addiction Research Foundation videotapes was developed to accompany the CIWA scale; the CIWA-Ar is a modified and shorter version of the CIWA scale. These tapes are entitled "Alcohol Withdrawal Syndrome" and were developed for the purpose of training clinical personnel experienced with alcohol problems. They could be used to train a variety of social service or health professionals and modified to augment the training of the volunteer.

46. Tim Stockwell, Denis Murphy and Ray Hodgson, The Severity of Alcohol Dependence Questionnaire: its use, reliability and validity, *British Journal of Addiction* 78 (1983):145-155.

47. The use of client support persons in assessment and in service delivery must be approached with caution and sensitivity to issues which concern women, the elderly, the young, the disabled and other potentially vulnerable populations.

48. The World Health Organization's 1991 publication, *Responding to drug and alcohol problems in the community,* offers additional guidance in this area, suggesting questions which could help to elicit the required information (see endnote 21).

49. Stockwell and Sue Clements, eds., *Helping the Problem Drinker: New Initiatives in Community Care* (New York/Sydney: Croom Helm, 1987): Chapter 10: The Exeter Home Detoxification Project.

    Tim Stockwell, Liz Bolt, Ingrid Milner, Peter Pugh and Ian Young, Home detoxification for problem drinkers: acceptability to clients, relatives, general practitioners and outcome after 60 days, *British Journal of Addiction* 85 (1990):61-70.

    Tim Stockwell, Liz Bolt, Ingrid Milner, Graham Russell, Helen Bolderston and Peter Pugh, Home detoxification from alcohol: its safety and efficacy in comparison with inpatient care, *Alcohol & Alcoholism* 26 (5/6) (1991):645-650.

    Although the Exeter Home Detox service has been discontinued, similar services have been and are being established elsewhere. The most recent and comprehensive look at Stockwell's home detox model is David B. Cooper, *Alcohol Home Detoxification and Assessment* (Oxford and New York: Radcliffe Medical Press, 1994).

50. Griffith Edwards, The practical business of treatment – 15. The alcoholism treatment services at the Maudsley Hospital, London, *British Journal of Addiction* 86 (1991):143-150.

51. Colin Bennie, Home and Dry, *Community Outlook* (October 1992):28-30.

52. David B. Cooper, *Alcohol Home Detoxification and Assessment*, see endnote 49.

53. Martha Sanchez-Craig, *Saying When. How to Quit Drinking or Cut Down. An ARF Self-Help Book* (Toronto: Addiction Research Foundation, 1993). *Saying When* is available through Marketing Services of ARF by calling 1-800-661-1111.

54. Prudence Breitrose, Volunteers. Volume I of *How-To Guides On Community Health Promotion* (Paulo Alto, California: Health Promotion Resource Centre, 1988).

55. Anne Bartu, and B. Saunders, Domiciliary vs inpatient detoxification for problem drinkers: a comparative matched study. Draft paper in preparation for publication as of 9/92 and Anne Bartu, Guidelines for the nursing management of alcohol related withdrawal symptoms in the home, *The Australian Nurses Journal* 21(4) (1991):12-13.

    Colin Bennie, Home detoxification service for problem drinkers: a pilot study, *Alcoholism* 1 (1992), and Home and Dry, *Community Outlook* (October 1992):28-30.

56. Andrew Johns, Volatile solvent abuse and 963 deaths, Editorial in *British Journal of Addiction* 86 (1991):1053-1056. This article describes a study by I. Sourindhrin and J.A. Baird, Management of solvent misuse: a Glasgow community approach, *British Journal of Addiction* 79 (1984):227-232.

57. Addiction Research Foundation, *The Journal* 20(8) (Dec 1991/Jan 1992):3. The Ranch Ehrlo Society in Regina is a residential centre for children with behavioral problems that has an eight bed program for solvent abusers of 12-15 years of age. They plan for a six month detoxification period and claim that "if you're not prepared to deal with them on a long term basis, you're wasting your money." There were, however, two similarities to the Glasgow project: the family is involved and a support network is developed in the community.

58. Addiction Research Foundation, *The Journal* 20(7) (Oct/Nov 1991):7-8.

59. Mark N. Collins, Tom Burns, Peter A.H. Van Den Berk and Gary F. Tubman, A structured programme for out-patient alcohol detoxification, *British Journal of Psychiatry* 156 (1990):871-874.

60. Motoi Hayashida, Arthur I. Alterman, A. Thomas McLellan, Charles P. O'Brien, James J. Purtill, Joseph R. Volpicelli, Arnold H. Raphaelson and Charles P. Hall, Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome, *The New England Journal of Medicine* 320(6) (1989):358-365.

61. Paul DeVenyi, M.D., and Sarah J. Saunders, M.D., eds. *Physician's Handbook for Medical Management of Alcohol- and Drug-Related Problems* (Toronto: Addiction Research Foundation/Ontario Medical Association, 1986).

62. Saskatchewan Alcohol and Drug Abuse Commission. Information about the Mobile Community Treatment project was published in *The Journal* Sept 1, 1990. Also, in *CCSA News Action* II (6) (Dec 1991).

63. Paul Hanki, Terry Clark and Tom Baker (undated manuscript), Report of the Nechako Centre Treatment Program.

64. The Ontario Ministry of Health, *Ontario Detoxification Program Service Implementation Plan,* August, 1992.

65. Kathryn Graham, Grace A. Woo, Cynthia Smythe, Pamela J. Brett, Virginia Carver, David DeWit, Steve Dooley, Louis Gliksman, Kristine Hollenberg, Scott Macdonald, Joan Marshman, Alan Ogborne and Brian Rush, *The Evaluation Casebook: Using Evaluation Techniques to Enhance Program Quality in Addictions* (Toronto: Addiction Research Foundation, 1994).

APPENDIX 1

DETOX CENTRE STATISTICS

March 1993

COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS — DETOXIFICATION CENTRES

STATISTICS FOR THE MONTH OF: MARCH 1993 — INTAKE - 1 of 2

PROGRAM NO	NAME	SEX	FIRST ADM	RE-ENTRY	TOTAL ADM. MONTH	TOTAL ADM. YTD	REFERRED BY: POLICE	HOSPITAL	REHAB.	SELF	PHYSI.	ASSESS/ REF.	FAM/FR AA/NA	OTHER AGENCY	AVGE. CL. AGE
1021	PLUMMER MEMORIAL	M	15	93	108	2014	6	9	1	83	2	0	7	0	41.8
	SAULT STE MARIE	F	4	15	19	203	4	1	1	11	0	0	2	0	36.7
1022	SUDBURY ALGOMA	M	21	216	237	2129	23	19	13	160	1	0	12	9	43.2
1060	SMOOTH ROCK	M	12	20	32	275	0	2	2	11	2	9	3	3	35.6
	FALLS	F	5	6	11	78	0	1	2	4	1	1	0	2	36.3
1064	NIPISSING - NORTH BAY	M	11	22	33	468	3	1	3	24	0	0	2	0	
		F	12	1	13	109	2	1	6	3	0	0	1	0	
1075	PINEGATE - SUDBURY	F	14	27	41	381	2	2	0	30	0	2	4	1	36.5
2012	LEWKIN	M	17	119	136	1340	51	23	0	47	0	0	5	10	44.4
	THUNDER BAY	F	6	9	17	245	6	6	0	3	0	0	1	1	32.3
2011	ALPHA DELTA CHI	M	16	266	284	2903	6	14	0	203	2	2	15	42	42.9
2013	KENORA	F	6	59	67	830	2	9	0	39	0	0	3	14	41.1
3035	ST JOSEPH'S	M	53	255	308	3192	78	19	7	140	2	3	40	19	42
	LONDON	F	20	13	33	332	9	3	4	7	0	0	9	1	34
3038	WINDSOR WESTERN	M	12	100	112	1271	18	10	0	54	1	1	11	17	41
3047	WOMEN'S - WINDSOR	F	12	11	23	345	1	3	0	6	0	0	5	8	32
3048	NON-MEDICAL	M	13	17	30	498	3	4	2	11	2	1	6	1	36
	OWEN SOUND	F	1	1	2	64	0	0	0	1	0	0	0	1	32
4043	KITCHENER-WATERLOO	M	22	142	164	2465	36	19	1	94	0	0	10	4	42
		F	7	5	12	151	1	1	0	3	1	0	6	0	33
4044	HAMILTON	M	24	116	140	1714	45	5	0	80	2	0	3	5	44
4045	HOTEL-DIEU - ST CATH	M	26	69	97	1364	12	12	6	39	1	2	21	4	42.6
4055	WOMEN'S - ST CATH	F	10	29	39	426	2	6	3	24	0	1	1	0	34
4067	HALDIMAND-NORFOLK	M	24	5	29	324	1	3	6	15	0	1	3	0	39
	SIMCOE	F	3	0	3	70	0	0	2	1	0	0	0	0	47.3
4068	WOMEN'S - HAMILTON	F	17	24	41	463	2	5	5	16	4	3	6	0	35.9
5038	COUNTY OF SIMCOE	M	25	24	49	647	1	11	0	25	3	0	5	4	38.6
	BARRIE	F	8	3	11	141	1	1	0	5	2	0	2	0	40
5068	PEEL MEMORIAL	M			0										
	BRAMPTON	F			0										
6074	WEST CENTRAL - TOR	M	52	196	248	2877	50	46	7	109	3	0	11	20	
6075	ARF - TORONTO	M	37	63	100	1376	27	6	10	44	2	2	6	3	39.9
		F	13	22	35	405	7	4	5	13	0	0	2	4	34.7
6076	EAST GENERAL - TOR	M	74	136	210	2319	53	18	16	96	2	1	8	14	41.2
6077	ST MICHAEL'S - TOR	M	36	161	217	2505	34	14	7	144	0	4	6	8	41
6078	ST JOSEPH'S - TOR	M	45	164	209	1827	17	29	2	129	0	0	18	14	41
6129	WOMEN'S - TORONTO	F	33	59	92	1161	3	9	7	50	0	0	9	14	34
7032	OTTAWA	M	63	235	298	4129	35	6	16	163	2	1	23	50	39
		F	10	22	32	509	4	2	3	16	0	0	1	6	29
7034	HOTEL DIEU	M	24	46	70	872	7	3	7	37	3	0	9	4	38
	KINGSTON	F	8	9	17	193	0	2	2	7	0	1	4	1	35
7043	CORNWALL AND AREA	M	31	32	63	710	3	6	10	34	1	0	5	4	36.5
	SOCIAL	F	3	6	9	101	1	0	2	5	0	0	0	1	41.3
MONTH TOTALS			853	2838	3691	43426	556	341	160	1986	39	35	285	289	3691

Community Mental Health and Addictions Programs

COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS — DETOXIFICATION CENTRES

INTAKE - 2 OF 2

SUMMARY - MONTH/YEAR	FIRST ADM.	RE-ENTRY	TOTAL ADM. MONTH	TOTAL ADM YTD	REFERRED BY: POLICE	HOSPITAL	REHAB.	SELF	PHYSI.	ASSESS/ REF.	FAM/FR AA/NA	OTHER AGENCY	
APRIL	941	2677	3618	3618	542	299	150	1933	35	29	271	359	
MAY	893	2961	3854	7472	585	288	132	2154	26	24	305	340	
JUNE	800	2801	3601	11073	548	292	141	2007	30	23	290	270	
JULY	829	3020	3849	14922	544	321	130	2210	34	25	278	309	
AUGUST	867	2957	3824	18748	570	309	146	2181	28	23	285	302	
SEPTEMBER	799	2846	3645	22391	487	276	178	2058	29	31	295	293	
OCTOBER	860	2939	3799	26190	530	336	141	2128	20	29	273	342	
NOVEMBER	813	2798	3611	29801	459	296	127	2078	31	32	273	317	
DECEMBER	729	2648	3377	33178	478	306	122	1981	15	20	244	233	
JANUARY	875	2578	3453	36631	474	322	181	1878	27	35	285	271	
FEBRUARY	724	2380	3104	39735	437	254	126	1755	31	18	231	252	
MARCH	853	2838	3691	43426	556	341	160	1986	39	35	285	289	
YEAR TOTALS:	9983	33443	43426		6208	3640	1714	24305	345	324	3313	3577	43426

COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS

COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS — DETOXIFICATION CENTRES

STATISTICS FOR THE MONTH OF: MARCH 1993

PROGRAM NO	NAME	SEX	TOTAL DISCH MONTH	TOTAL DISCH YTD	TO HOSPITAL: WITH-DRAWAL	TO HOSPITAL: MEDICAL REASONS	ACTUAL HOSP ADM	ASSESS/ REF	RESI: LONG TERM	TREAT: SHORT TERM	REFERRALS - 1 of 2: HOSTEL	AA/ NA	OUT-PATIENT COUNSEL	OTHER AGENCY	NO APP. REF.RES. AVAIL	NO REFERRAL ACCEPTED	AVGE CL. DAYS	AVGE CLIENT HOURS
1021	PLUMMER MEMORIAL, SAULT STE MARIE	M	112	2018	4	3	3	0	8	1	0	5	1	1	0	92	2.7	38.7
		F	19	202	0	3	0	0	1	0	0	1	0	2	0	15	2.5	34.5
1022	SUDBURY ALGOMA	M	237	2116	4	1	4	0	7	3	4	2	0	0	10	206	2	35.8
1060	SMOOTH ROCK FALLS	M	29	278	3	3	7	10	2	6	0	12	0	0	0	7	4.4	62.1
		F	10	75	0	4	3	4	2	1	0	7	0	0	0	2	7.6	157.9
1064	NIPISSING - NORTH BAY	M	36	475	0	2	0	1	2	5	0	4	6	4	16	5	2.4	43.3
		F	17	114	0	3	1	2	0	3	0	2	5	1	6	3	2.4	52
1075	PINEGATE - SUDBURY	F	41	377	1	2	0	3	5	3	0	31	2	4	29	13	4.1	99.4
2012	LEWKIN THUNDER BAY	M	143	1340	9	13	3	0	0	0	0	1	0	4	0	135	1.6	29.6
		F	19	244	0	1	1	0	0	1	0	1	0	2	0	14	2.6	50.5
2031	ALPHA DELTA CHI	M	287	2937	0	13	1	0	0	7	9	19	0	2	0	11	2.7	34.5
2033	KENORA	F	62	619	1	2	1	0	0	4	1	2	0	1	0	13	2.7	36.3
3035	ST JOSEPH'S LONDON	M	308	3192	2	1	1	0	1	27	11	67	1	0	0	140	3.1	49.3
		F	33	332	1	0	1	0	0	6	2	16	2	0	0	1	4.2	76.7
3038	WINDSOR WESTERN	M	114	1272	3	6	5	0	0	13	0	12	0	0	0	89	2.6	51.2
3047	WOMEN'S - WINDSOR	F	25	346	2	2	4	0	0	11	0	0	0	0	0	10	4	83.6
3048	NON-MEDICAL OWEN SOUND	M	26	494	1	2	1	0	0	6	0	11	2	10	0	5	4.5	61.6
		F	2	65	0	0	0	0	0	1	0	1	0	2	0	0	6	123.4
4043	KITCHENER-WATERLOO	M	166	2448	0	0	2	2	22	1	6	10	0	0	0	131	3	52.6
		F	11	151	0	0	0	0	2	2	0	5	1	0	0	4	6	100
4044	HAMILTON	M	146	1712	0	2	2	3	3	4	6	37	17	1	11	75	2.6	38.2
4045	HOTEL-DIEU - ST CATH	M	105	1368	3	5	2	5	4	6	2	16	2	2	0	64	4	96
4055	WOMEN'S - ST CATH	F	37	422	3	7	3	2	1	13	0	14	4	9	0	7	4.8	116.1
4057	HALDIMAND-NORFOLK SIMCOE	M	30	322	0	0	0	0	0	9	0	21	0	0	0	0	3.8	86.7
		F	4	70	0	0	0	0	0	2	0	2	0	0	0	0	4.5	124.1
4066	WOMEN'S - HAMILTON	F	45	466	5	6	1	12	11	6	1	26	6	5	0	7	2.9	46
5038	COUNTY OF SIMCOE BARRIE	M	45	641	5	2	5	0	1	5	0	1	0	2	26	5	2.2	51.6
		F	10	134	2	1	2	0	2	1	0	3	0	1	2	0	5.1	121.5
5064	PEEL MEMORIAL BRAMPTON	M																
		F																
6074	WEST CENTRAL - TOR	M	246	2677	4	15	3	0	15	1	7	22	1	0	5	219	2.6	34
6075	ARF - TORONTO	M	96	1371	6	2	0	2	13	10	2	16	6	6	0	58	4.9	90.9
		F	35	408	2	1	0	2	3	9	2	6	3	3	2	15	4.5	86.1
6076	EAST GENERAL - TOR	M	207	2314	7	7	1	0	7	21	3	11	0	6	0	158	2.1	40.6
6077	ST MICHAEL'S - TOR	M	221	2504	5	12	3	1	14	4	0	0	2	0	6	191	2.6	62.2
6078	ST JOSEPH'S - TOR	M	209	1627	4	4	1	0	15	20	2	6	0	0	0	166	3	50.4
6139	WOMEN'S - TORONTO	F	69	1139	7	10	4	1	0	16	10	36	1	0	0	18	5.6	116.5
7032	OTTAWA	M	295	4101	2	7	0	1	50	12	10	9	3	0	0	201	2.6	40.7
		F	36	517	0	2	0	2	6	2	2	0	0	0	0	22	3.5	59.8
7054	HOTEL DIEU KINGSTON	M	88	867	0	1	0	13	0	14	4	23	9	3	0	33	3.6	62.8
		F	16	185	1	0	0	1	0	6	0	6	2	1	0	6	4.5	90.3
7043	CORNWALL AND AREA SOCIAL	M	60	702	0	16	0	1	7	6	3	3	0	0	2	35	3	48.9
		F	9	99	0	1	0	0	1	1	0	0	0	0	0	4	2.6	61
MONTH TOTALS			3714	43341	87	166	65	68	205	277	87	475	78	72	115	2180		

Community Mental Health and Addictions Programs

COMMUNITY MENTAL HEALTH AND ADDICTIONS PROGRAMS — DETOXIFICATION CENTRES

SUMMARY - MONTH YEAR	TOTAL DISCH. MONTH	TOTAL DISCH. YTD	TO WITH-DRAWAL	HOSPITAL MEDICAL REASONS	ACTUAL HOSP. ADM.	ASSESS/ REF.	RESI. LONG TERM	TREAT. SHORT TERM	REFERRALS - 2 OF 2 HOSTEL	AA/ NA	OUT-PATIENT COUNSEL	OTHER AGENCY	NO APP. REF. RES AVAIL.	NO REFERRAL ACCEPTED
APRIL	3635	3635	111	149	50	43	256	302	88	420	102	39	35	2155
MAY	3839	7474	89	138	32	74	220	249	89	384	87	41	84	2471
JUNE	3605	11079	96	118	45	47	182	274	83	384	55	84	34	2228
JULY	3804	14883	107	121	36	63	211	263	89	420	62	77	46	2441
AUGUST	3794	18677	108	165	51	56	197	264	108	414	74	73	51	2442
SEPTEMBER	3652	22329	103	124	34	77	218	301	101	445	69	60	40	2247
OCTOBER	3806	26135	119	166	56	62	209	247	108	415	48	73	29	2380
NOVEMBER	3634	29769	92	130	47	76	209	271	85	378	52	94	60	2116
DECEMBER	3370	33139	61	115	48	47	185	184	91	351	45	55	44	2070
JANUARY	3371	36510	81	141	45	54	217	290	80	378	61	63	43	1872
FEBRUARY	3117	39627	97	129	55	88	184	257	74	372	91	77	72	1754
MARCH	3714	43341	87	166	65	68	205	277	87	475	78	72	115	2180
YEAR TOTALS	43341		1151	1662	562	755	2493	3179	1083	4832	824	808	653	26356

APPENDIX 2

CIWA-Ar SCALE

Addiction Research Foundation

SADQ

Stockwell, et al.

Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol (CIWA Ar)

Appendix: Addiction Research Foundation Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)

Patient_____ **Date** |_|_|_|_|_|_| y m d **Time**____:____ **(24 hour clock, midnight=00:00)**

Pulse or heart rate, taken for one minute: _____ **Blood pressure:** _____/_____

NAUSEA AND VOMITING—As "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR—Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS—Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY—Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION—Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES—Ask "Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES—Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES—Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD—Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM—Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Total CIWA-A Score_____
Rater's Initials_____
Maximum Possible Score 67

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE (SADQ)

SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE

RESPONDENT CODE ☐☐☐

First of all, we would like you to recall a recent month when you were drinking heavily in a way which, for you, was fairly typical of a heavy drinking period. Please fill in the month and the year.

MONTH ..... **YEAR** .....

We would like to know more about your drinking during this time and during other periods when your drinking was similar. We want to know how often you experienced certain feelings. Please reply to each statement by putting a circle round **ALMOST NEVER** or **SOMETIMES** or **OFTEN** or **NEARLY ALWAYS** after each question.

First we want to know about the physical symptoms that you have experienced first thing in the morning during these typical periods of heavy drinking.

PLEASE ANSWER EVERY QUESTION

1 During a heavy drinking period, I wake up feeling sweaty.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

2 During a heavy drinking period, my hands shake first thing in the morning.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

3 During a heavy drinking period, my whole body shakes violently first thing in the morning if I don't have a drink.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

4 During a heavy drinking period, I wake up absolutely drenched in sweat.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

The following statements refer to moods and states of mind you may have experienced first thing in the morning during these periods of heavy drinking.

5 When I'm drinking heavily, I dread waking up in the morning.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

6 During a heavy drinking period, I am frightened of meeting people first thing in the morning.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

7 During a heavy drinking period, I feel at the edge of despair when I awake.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

8 During a heavy drinking period, I feel very frightened when I awake.

ALMOST NEVER **SOMETIMES** **OFTEN** **NEARLY ALWAYS**

Severity of Alcohol Dependence Questionnaire (SADQ)

PLEASE ANSWER EVERY QUESTION

The following statements also refer to the recent period when your drinking was heavy, and to periods like it.

9 During a heavy drinking period, I like to have a morning drink.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

10 During a heavy drinking period, I always gulp my first few morning drinks down as quickly as possible.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

11 During a heavy drinking period, I drink in the morning to get rid of the shakes.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

12 During a heavy drinking period, I have a very strong craving for a drink when I awake.

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

Again the following statements refer to the recent period of heavy drinking and the periods like it.

13 During a heavy drinking period, I drink more than a quarter of a bottle of spirits per day (4 doubles or 1 bottle of wine or 4 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

14 During a heavy drinking period, I drink more than half a bottle of spirits per day (or 2 bottles of wine or 8 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

15 During a heavy drinking period, I drink more than one bottle of spirits per day (or 4 bottles of wine or 15 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

16 During a heavy drinking period, I drink more than two bottles of spirits per day (or 8 bottles of wine or 30 pints of beer).

ALMOST NEVER SOMETIMES OFTEN NEARLY ALWAYS

IMAGINE THE FOLLOWING SITUATION -
(1) You have been COMPLETELY off drink for a FEW WEEKS,
(2) You then drink VERY HEAVILY for TWO DAYS,

HOW WOULD YOU FEEL THE MORNING AFTER THOSE TWO DAYS OF HEAVY DRINKING?

17 I would start to sweat.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

18 My hands would shake.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

19 My body would shake.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

20 I would be craving for a drink.

NOT AT ALL SLIGHTLY MODERATELY QUITE A LOT

APPENDIX 3

DETOX TRANSPORTATION PAPER

Community Mental Health Branch of the
Ontario Ministry of Health

APRIL 30, 1992

ORDER IN COUNCIL

Detox Transportation Paper

Ministry of Health / Ministère de la Santé
Ontario

Community Mental Health Branch
Direction des services communautaires de santé mentale

4th Floor
15 Overlea Boulevard
Toronto, Ontario
M4H 1A9
(416) 327-7239
Fax: (416) 327-7281

4e étage
15, boulevard Overlea
Toronto (Ontario)
M4H 1A9
(416) 327-7239
Télécopieur : (416) 327-7281

January 5, 1993

Mr. Bruce Taylor
Chairperson
Ontario Detox Directors' Association
394 West Street
Simcoe, Ontario
N3Y 1T9

Dear Mr. Taylor:

The *Detox Transportation* paper has been revised following further consultation with staff from the Ministry of Health's Legal Services Branch. I have enclosed the revised version; it will replace the paper I gave you previously. I am optimistic that you will find the information useful.

Thanks for giving the Ministry of Health the opportunity to help.

Sincerely,

Dennis Helm
Manager,
Program Operations

/dh

DETOX TRANSPORTATION PAPER

December 1992

DETOX TRANSPORTATION

ISSUE: Referral and safe transportation of intoxicated individuals to a detox centre.

BACKGROUND:

The transportation issues that have arisen have generally been in relation to a detox centre that is located some distance from major population centres.

For example, Smooth Rock Falls Detox Centre is the only detox centre serving communities in the Cochrane District. It is situated approximately 100 kilometres from Timmins (population 49,000), approximately 1 hour and 20 minutes driving time along an isolated highway.

There is no formal transportation system developed to transport individuals from the surrounding communities to the detox centre. It appears that one assessment/referral agency will not refer intoxicated individuals to the Detox Centre because of third party liability. Currently, the agency refers such individuals to the hospital's emergency department located in Timmins.

This fear of liability may not be entirely justifiable, depending in part on whether the agency is alleged to be vicariously liable, in the absence of fault, for the actions of its employees or agents, or directly liable for its own wrongdoing.

Moreover, the agency's refusal to deal in some way with intoxicated individuals could be actionable negligence in certain circumstances. This argument may be buttressed if, for example, the local hospital has no facilities, and lawfully refuses, to treat non-medical intoxication.

The Ontario Detox Directors' Association requested that the Ministry of Health review the transportation issue. Specifically, the Association identified four major issues requiring clarification. These are accessing the detoxification service, accessing medical care for non-emergency services, courier services for the portering of goods and liability issues when volunteers are utilized.

DETOX TRANSPORTATION PAPER

ISSUE: ACCESSING THE SERVICE

POSITION:

Referral Responsibility (Assessment/Referral Service)

- General assessment of individuals according to established criteria
- In most instances, referrals would be made to treatment services, possibly utilizing DART.
- Referral to detox centre or, if deemed necessary, to family physician/emergency department of hospital.
- If referring to detox, staff should contact the detox to determine if the detox can admit the individual (whether space is available and whether the individual is eligible for admission).
- If the individual cannot arrange for transportation, staff should offer to make arrangements (determine what possible modes of transportation and payment are available. For example, transportation through family/friends, public transportation, volunteers, etc. Payment can come from the individual, social assistance, the Northern Health Travel Grant, the agency, etc.).

Role of Police

- The police are authorized to bring a person into one of the 15 hospitals designated in the Liquor Licence Act, O. Reg. 547/90, s. 4. A number of hospitals sponsoring detox centres are not yet included. Legal Services Branch has an updated list of hospitals sponsoring detox centres which will be used to revise this regulation.

Role of the Ambulance System

- An intoxicated individual may be transported to a facility by ambulance only where that individual requires medical attention or is under medical care, and where the ambulance driver has been properly authorized to do so.
- Ambulance personnel may make a general assessment (scene survey, primary and secondary survey, and patient history) whether an intoxicated individual requires hospital/medical attention or detoxification. In some circumstances, the need for detoxification may in itself be a medical condition requiring medical attention. In other cases, ambulance personnel may determine, on the basis of their general assessment, that the individual needs medical attention only during transportation. In yet other instances, there is no need for anything but detoxification.

DETOX TRANSPORTATION PAPER

- If hospital/medical attention is required, upon proper authorization the intoxicated individual may be transported by ambulance. If the only need is to transport the individual to a detox centre, but no immediate or future hospital/medical attention is believed to be required, the individual may not be transported by ambulance.

Role of Emergency Department of Hospital

- The hospital should seek its own legal advice in setting up a policy pertaining to referral of intoxicated individuals.
- If assessed as not requiring medical attention, a referral should be made to the detox centre.
- The detox should be contacted to determine if the individual can be admitted, and, if necessary, to make arrangements for transportation.
- If the person is intoxicated and detoxification is not in and of itself a medical condition, the hospital has no legal obligation to admit the person.

Role of Detox Staff

- Detox staff are trained to do a general assessment of a client according to set criteria before admitting the individual to the detox centre.
- Detox staff should inform the referral sources about whether or not they can admit the individual in question.
- Under special circumstances, the detox at their own discretion may arrange and/or pay for transportation of the individual.

Criteria for Transportation

- The order in which transportation options should be considered is the following:
  1. client-funded/organized
  2. family/friends
  3. unpaid volunteers
  4. subsidized by social assistance (Welfare Office)
  5. Northern Travel Grant Program - where applicable
  6. subsidized by agency (includes paying volunteers for transportation)

DETOX TRANSPORTATION PAPER

Northern Health Travel Grant Program (NHTG)

- The program was established to help pay the travel costs of northern Ontario residents who are referred for specialist and hospital services not currently available in their own communities. The mandate has been recently expanded to include all Ministry-funded alcohol and drug-dependency services.

- People are eligible for reimbursement of travel costs if:
  - they live north of the District of Parry Sound, including all of the District of Nipissing
  - they are referred by a northern Ontario physician
  - one-way distance for travel within northern Ontario is 100 km and for travel to southern Ontario is 200 km

- Third party status could be granted to social services, municipalities and addiction services, such as detox centres and assessment/referral services.

  Third party status allows the service to pay up-front for transportation of clients who have been referred by a physician, and get reimbursed from the NHTG program. The service needs to write a letter to the NHTG program requesting 3rd party status.

- The contact person for the program is Dorothy MacCrae, Co-ordinator, (613) 548-6659 in Kingston.

LIABILITY

Assumption: Intoxicated individuals may be competent to give consent, including consent to travel to the detox centre before transportation is arranged. In order to assess competence, a trained health care provider should be involved. The assessor should assess on the basis of well-developed assessment criteria. The following comments only apply if the intoxicated person is assessed as competent.

There are a number of liability issues at stake:

1. The referring agency's or hospital's liability for injuries that their volunteer driver might incur in transporting clients to detoxes.

DETOX TRANSPORTATION PAPER

2. The referring agency's or hospital's direct liability for injuries that the intoxicated person might incur while being transported to a detox centre.

3. The referring agency's or hospital's vicarious liability for injuries that the intoxicated person might incur because of the actions of its volunteers while such person is being transported to a detox centre.

Position of Volunteers

a. compensation is not paid for travel
   - Volunteers are bound by the Highway Traffic Act.
   - They should accept full responsibility when they agree to transport an intoxicated individual to detox. This acceptance should be formalized and documented.
   - The volunteer may not be held liable if the volunteer is judged as having behaved like a "reasonable man".
   - As the volunteer is simply acting like a good samaritan, the car insurance company would respond should there be an accident and the passenger was injured.
   - They should have sufficient car insurance coverage, at least $1,000,000.
   - The associated agency should verify whether the volunteer and your agency have proper insurance coverage.

b. compensation is given for travel
   - Same as above, except that should an accident occur, the volunteer could find himself/herself legally liable; the car insurance company would not respond.

Position of the Agency for which volunteers are used

- A screening procedure for volunteers and guidelines for the transportation of intoxicated individuals should be developed.
- The agency may be held liable for injuries sustained by volunteers and their passengers, whether the volunteers are or are not compensated by the agency.
- Proper insurance coverage should be secured and verified.

Detox Transportation Paper

Position of referring agency

- Referring agency should make every effort possible to ensure that the intoxicated person will travel safely.
- It would be best if a policy is developed which sets out in what circumstances a referral must be made to a physician rather than to the detox centre; if not, detox staff should be contacted to make this determination.
- Referring staff/agency will not be held liable if staff/agency acted professionally and reasonably in dealing with the intoxicated person.
- Staff and agency liability insurance is there to protect the staff and agency.
- If a medical misadventure occurs en route to the detoxification centre, the agency will not be held liable for injuries sustained by the intoxicated person or volunteer driver if it was reasonable for the intoxicated person to travel to the centre, bearing in mind the person's physical and apparent medical condition, the distance to be travelled, the mode of travel provided, whether the intoxicated person was competent to give consent to travel and has consented, and all other relevant circumstances. One hundred kilometres could be considered to be an unreasonable distance to transport an intoxicated person.
- With regard to volunteer drivers, the organization that arranged for transportation has a clear duty of care toward them. There is a duty to warn; the organization must inform the volunteer drivers about the risks associated with transporting intoxicated people.

Smooth Rock Falls Detox Centre has developed a transportation system for intoxicated individuals from the Cochrane District to the detox centre. An intake assessment form to be used during telephone contacts with referral services is in the process of being developed. The Community Mental Health Branch has provided additional funding to reimburse volunteers at $0.25/km for the transportation of individuals. A screening procedure and guidelines for volunteers has been developed. The volunteer signs a waiver releasing the detox centre from all damages (it is uncertain whether this waiver would carry any weight in a court of law). It appears that volunteers are not being used much at this time because of difficulty in securing them when needed. The detox centre has gained third party status with the Northern Health Travel Grant Program. As such, the detox centre is reimbursed for travel costs incurred for the transportation of individuals from Timmins and Hearst (when they are referred by a physician).

ORDER IN COUNCIL

Ontario
Executive Council
Conseil des ministres

Order in Council
Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Sur la recommandation du soussigné, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil des ministres, décrète ce qui suit :

pursuant to subsection 4(2) of the Public Hospitals Act, R.S.O. 1990, c. P.40, as amended, the operation or use of the following premises are approved for the purposes of a hospital:

As part of the Royal Victoria Hospital in Barrie - The Community Care Centre for Substance Abuse
70 Wellington Street West
Barrie, Ontario
L4N 1K4

As part of the Cornwall General Hospital - Cornwall & Area Social Detox Program
305 Montreal Road
Cornwall, Ontario
K6H 1B6

As part of the Hamilton Civic Hospital - Hamilton Men's Detox Centre
132 Wilson Street East
Hamilton, Ontario
L8L 222

As part of the St. Joseph's Hospital in Hamilton - Hamilton Women's Detox Centre
48 Rosslyn Avenue North
Hamilton, Ontario
L8L 7P2

As part of the Lake of the Woods District Hospital in Kenora - Alpha Delta Chi House
6 Matheson Street South
Kenora, Ontario
P9N 1T5

As part of the St. Joseph's Health Care Centre in London - St. Joseph's Detoxification Centre
471 William Street
London, Ontario
N6B 3E4

As part of the St. Joseph's General Hospital of North Bay Inc. - Nipissing Centre
720 McLaren Street
North Bay, Ontario
P1B 3L9

As part of the Elizabeth Bruyère Hospital in Ottawa - Ottawa Detoxification Centre
at 62 Bruyère Street
Ottawa, Ontario
K1N 5C5; and

at 99 and 991/2 Bruyère Street
Ottawa, Ontario
K1N 5C7

As part of the Grey Bruce Regional Health Centre - Grey Bruce Non-Medical Detoxification Centre
495 9th Avenue East
P.O. Box 1400
Owen Sound, Ontario
N4K 6M9

O.C./Décret 1238/92

ORDER IN COUNCIL

As part of the Hotel Dieu Hospital in Kingston -
Hotel Dieu Detox
240 Brock Street
Kingston, Ontario
K7L 1S4

As part of the Kitchener-Waterloo Hospital -
Waterloo Regional Detoxification Unit
466 Park Street
Kitchener, Ontario
N2G 1N6

As part of the Smooth Rock Falls Hospital -
Smooth Rock Falls Detoxification Centre
105 Second Avenue
P.O. Box 460
Smooth Rock Falls, Ontario
P0L 2B0

As part of the Sudbury Algoma Hospital - Sudbury Algoma Hospital Detoxification Centre (Men)
109 Elm Street
Sudbury, Ontario
P3C 1T4

As part of the Sudbury Algoma Hospital - Pinegate Women's Detoxification Service
366 Pine Street
Sudbury, Ontario
P3C 5N2

As part of the Hotel Dieu Hospital in St. Catharines - Niagara Regional Detoxification Centre
10 Adams Street
St. Catharines, Ontario
L2R 2V8

As part of the Norfolk General Hospital -
Haldimand-Norfolk Detoxification and Rehabilitation Service
394 West Street
Simcoe, Ontario
N3Y 1T9

As part of the St. Michael's Hospital - St. Michael's Hospital Detoxification Centre
314 Adelaide Street East
Toronto, Ontario
M5V 1N1

As part of the Toronto East General and Orthopaedic Hospital -
Toronto East General Hospital Detoxification Centre
109 Knox Avenue
Toronto, Ontario
M4L 2P1

As part of the St. Joseph's Health Centre in Toronto -
St. Joseph's Health Centre Detoxification Unit
2769 Dundas Street West
Toronto, Ontario
M6P 1Y4

As part of Doctors' Hospital -
Woman's Own Detox Centre -
892 Dundas Street West
Toronto, Ontario
M6J 1W1

As part of the Windsor Western Hospital - Windsor Western Hospital Men's Detox Centre
363 Mill Street
Windsor, Ontario
N9C 3Z4

ORDER IN COUNCIL

As part of the Hotel Dieu Hospital in St. Catharines -
The Regional Niagara Women's Detoxification Centre
6 Adams Street
St. Catharines, Ontario
L2R 2V8

As part of the St. Joseph's General Hospital in Thunder Bay -
Balmoral Centre
667 Sibley Drive
P.O. Box 3251
Thunder Bay, Ontario
P7B 5G7

As part of the Toronto Hospital -
Toronto Hospital Western Division
Detoxification Unit
16 Ossington Avenue
Toronto, Ontario
M6J 2Y7

As part of the Plummer Memorial Hospital in Sault Ste. Marie - Sault Ste. Marie Detoxification Centre
911 Queen Street East
Sault Ste. Marie, Ontario
P6A 2B6

As part of the Windsor Western Hospital - Windsor
Western Hospital Women's Detox Centre
3765 Glenfield Avenue
Windsor, Ontario
N9C 2B3

As part of the Peel Memorial Hospital -
to be built on
Part of Lot 4, Concession 2
West of Hurontario Street
McLaughlin Road
Brampton, Ontario

As part of the Alcoholism and Drug Addiction Research Foundation -
Addiction Research Foundation
Detoxification Unit
501 Queen Street West
Toronto, Ontario
M5V 2B4

Recommended

Minister of Health Concurred Chair of Cabinet

Approved and Ordered April 30,1992
Date

Lieutenant Governor

APPENDIX 4

BIBLIOGRAPHY

The publications referenced below are organized in an unconventional manner that we hope will be helpful to a reader searching for information in a specific area.

We have arranged the materials first by topic and then in reverse chronological order, with the newest materials listed first.

TOPICS PAGE

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APPENDIX 5

KEY CONTACTS IN PLANNING WITHDRAWAL MANAGEMENT SERVICES

The questions posed in this guide remain as a challenge to community planning groups, the Ontario Ministry of Health, the Addiction Research Foundation, and the Ontario Detox Directors' Association. These challenges will only be met by collaborative discussion that promotes the exchange and updating of information. The following list of key contacts is a first step in developing a structure for information exchange. They are listed under the following headings:

As a first step in the process of collaborative discussion, the Rural Detox Committee solicited comments about an earlier draft of this planning guide. We are grateful for the contributions of the individuals who provided valuable suggestions that have been incorporated into the guide. The names of these individuals either bear an asterisk or are listed near the end of Appendix 5.

Addiction Research Foundation Rural Detox Committee

The following are current committee members who can be contacted for additional information:

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119 Pine Street South, Suite 324
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15150 Yonge Street, Suite 201
Aurora, Ontario L4G 1M2
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Jeff Wilbee
Executive Director
Alcohol and Drug Recovery
Association of Ontario
690 Fountain Street North
Cambridge, Ontario N3A 4R7
519-650-1140

Withdrawal Management Planning Initiatives in Ontario

The following includes only those planning initiatives in Ontario with which the planning committee has had contact during the development of this guide. We hope that the list will expand as a result of networking and collaborative discussions.

Timiskaming Detox Planning Committee
61 5th Street
Englehart, Ontario POJ 1H0
Contact: **Fran Nychuk***
705-544-2301

The Manitoulin Island Detoxification Planning Coalition
Mindemoya Hospital
Mindemoya, Ontario POP 1S0
Contact: **Glenn Hallett**
705-377-5311

Cochrane District Detox Planning Committee
Timmins Chamber of Commerce
76 McIntyre Road
Schumacher, Ontario PON 1G0
Contact: **Bob Bielek**
705-360-1900

Le Conseil de Planification
178 Main Street East
Hawkesbury, Ontario K6A 1A5
Contact: **Manon Lacelle-Lacroix**
1-800-267-0852

Addiction Task Force for York Region
Coordination and Advisory Council for Mental Health Services in York Region
171 Main Street South, Suite 6
New Market, Ontario L3Y 3Y9
Contact: **Bryan Salmers**
905-841-7007 ext. 27

Haliburton, Kawartha and Pine Ridge Detox Planning Group
c/o Addiction Research Foundation
223 Aylmer Street North, Suite 07
Peterborough, Ontario K9J 3K3
Contact: **Brian Mitchell**
705-748-9830

Detox Issues Working Group
c/o Brant DHC
233 Colborne Street, Suite 304
Brantford, Ontario N3T 2H4
Contact: **Catherine Knipe**
519-756-1330

Addiction Services Advisory Committee
Kent County District Health Council
75 Thames Street
Chatham, Ontario N7L 1S4
Contact: **Ron Shaw**
519-351-1162

Wellington Detox Planning Group
Community Alcohol and Drug Services
49 Emma Street, Suite 100
Guelph, Ontario N1E 6X1
Contact: **Stephen Pierce**
519-836-5733

Ontario Detox Centres

Co-ordination and planning among the following services is conducted by the Ontario Detox Directors' Assocation, which can be reached through any detox centre.

Community Care Centre for Substance Abuse
70 Wellington Street West
Barrie, Ontario L4N 1K4
Director: **Ted Ryan**
705-728-4226

Cornwall & Area Social Detox Program
305 Montreal Road
Cornwall, Ontario K6H 1B6
Director: **Bonnie Lemoyne**
613-938-8506

Hamilton Men's Detox
132 Wilson Street
Hamilton, Ontario L8R 1E2
Director: **Rod McEwen**
905-527-9264

Kenora Detox Centre
6 Matheson Street South
Kenora, Ontario P9N 1T5
Director: **David Novak**
807-468-5631

Waterloo Regional Detox
466 Park Street
Kitchener, Ontario N2G 1N6
Director: **Mervyn Mothersell**
519-749-4300 ext. 2623

Nipissing Detox
720 McLaren Street
North Bay, Ontario P1B 3L9
Director: **Phyllis Palangio**
705-495-8130

Peel Memorial Regional Detox
156 John St., 1st Floor
Brampton, Ontario L6W 2A1
Director: **Frank Caswell**
905-456-3500

The Oaks Centre Detox Services
c/o 70 Spine Road
Elliot Lake, Ontario P5A 1X2
Director: **Arthur McCord**
705-461-4508

Hamilton Women's Detox
48 Rosslyn Avenue North
Hamilton, Ontario L8L 7P2
Director: **Lorraine Chapman***
905-545-9100

Hotel Dieu Detox
240 Brock Street
Kingston, Ontario K7L 1S4
Director: **Gerry Gregory**
613-549-6461

St. Joseph's Detox
471 William Street
London, Ontario N6B 3E4
Director: **Bob Fleming**
519-432-7241

The Toronto Hospital Detox Unit
16 Ossington Avenue
Toronto, Ontario M6J 2Y7
Director: **Hugh Naugler**
416-533-7945

ARF Detox Program
501 Queen Street West
Toronto, Ontario M5V 2B4
Director: **Michael Dean***
416-868-1993

Toronto East General Detox
985 Danforth Avenue
Toronto, Ontario M4J 1M1
Director: **Norm Murray***
416-461-2010

Woman's Own
892 Dundas Street West
Toronto, Ontario M6J 1W1
Director: **Berit Dullerud**
416-367-0235

Windsor Women's Detox
3765 Glenfield Avenue
Windsor, Ontario N9C 3Z4
Director: **Dr. Carmela Pakula**
519-257-5226

Pinewood Detox
300 Centre Street South
Oshawa, Ontario L1H 4B2
Director: **Dr. Brian McLatchie**
905-723-8195

Sault Ste. Marie Detox
911 Queen Street East
Sault Ste. Marie, Ontario P6A 2B5
Director: **Carole Swan**
705-942-1872

Cochrane District Detox
P.O. Box 460
Smooth Rock Falls, Ontario POL 2B0
Director: **Joanne Bezzubetz**
705-338-2761

St. Michael's Detox
314 Adelaide Street East
Toronto, Ontario M5V 1R1
Director: **John Rutledge**
416-864-5078

St. Joseph's Health Centre
30 The Queensway
Ground Floor, East Wing
Toronto, Ontario M6R 1B5
Director: **Veronica Alexis**
416-530-6400

Windsor Men's Detox
363 Mill Street
Windsor, Ontario N9C 3Z4
Director: **Dr. Carmela Pakula**
519-257-5225

Ottawa Detox
62 Bruyere Street
Ottawa, Ontario K1N 5C5
Director: **Marc Lavigne**
613-241-1525

Grey/Bruce Detox
495 9th Avenue East, Box 1400
Owen Sound, Ontario N4K 6M9
Director: **Paul Wagler***
519-376-5666

Holmes House
394 West Street
Simcoe, Ontario N3Y 1T9
Director: **Bruce Taylor**
519-428-1911

Sudbury Detox Centre for Men
109 Elm Street West
Sudbury, Ontario P3C 1T4
Director: **Barbara Deschamps**
705-674-3330

Pinegate Women's Detox Service
336 Pine Street
Sudbury, Ontario P3C 1X8
Executive Director: **Babara Deschamps**
705-671-7167

Hotel Dieu Women's Detox
6 Adams Street
St. Catharines, Ontario L2R 2V8
Executive Director: **Norma Medulun**
905-687-9721

Hotel Dieu Men's Detos
10 Adams Street
St. Catharines, Ontario L2R 2V8
Executive Director: **Norma Medulun**
905-682-7211

Balmoral Centre
667 Sibley Drive, P.O. Box 3251
Thunder Bay, Ontario P7B 5G7
Executive Director: **John LaForest**
807-623-6515

District Health Council of Ontario

Co-ordination and planning among District Health Councils is conducted by the Association of District Health Councils.

Association of District Health Councils of Ontario
4141 Yonge Street, Suite 201
Willowdale, Ontario M2P 2A8
Executive Director: **John Butler**
416-222-1445

Brant DHC
233 Colborne Street, Suite 304
Brantford, Ontario N3T 2H4
Executive Director: **Catherine Knipe**
519-756-1330

Durham Region DHC
1614 Dundas Street East, Suite 214
Whitby, Ontario L1N 8Y8
Executive Director: **Lynda Hessey**

East Muskoka/Parry Sound DHC
P.O. Box 3000, 36 Chaffey Street
Huntsville, Ontario P0A 1K0
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Grey-Bruce DHC
733-9th Avenue East, Unit 4
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123 March Street, Suite 405
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EXECUTIVE SUMMARY:

**A guide for
planning withdrawal management services
in rural and remote areas
and small urban centres of Ontario.**

EXECUTIVE SUMMARY:

A guide for planning withdrawal management services in rural and remote areas, and small urban centres of Ontario.

This Executive Summary provides only an overview of *A Guide for Planning Withdrawal Management Services in Rural and Remote Areas and Small Urban Centres of Ontario.* We recommend that interested community planners obtain the complete guide by contacting the nearest District Health Council, Detox Centre or Addiction Research Foundation office.

Introduction to the guide

In this planning guide, the Rural Detox Committee of the Addiction Research Foundation discusses how to plan *withdrawal management services* -- services that help people while their bodies get rid of alcohol and other drugs and adapt to a drug-free state. The guide is for community groups who either wish to establish a service in a rural or remote area or a small urban centre, or to improve an existing service. It encourages these groups to explore different options for service delivery, to discuss key issues in withdrawal management, and to develop comprehensive and cost-effective service plans.

The guide begins with background information to introduce the key issues of withdrawal management and review Ontario's approach, which favors the social setting detox centre. Next, we discuss some preliminary considerations and explain our framework for planning withdrawal management services. The framework's four components are: Service Awareness, Assessment, Managing Withdrawal, and Planning for Continuing Treatment. We illustrate each component with examples from the research literature and incorporate considerations for Ontario's rural and remote areas and small urban centres. The guide closes by briefly considering the final planning steps: proposal writing and evaluation.

To help community groups make practical use of the information in this guide, we summarize each chapter in a series of questions that groups can use as they address different aspects of planning. By using these questions as a starting point for discussion, a planning group can explore the various alternatives, develop a comprehensive service plan, and begin writing a proposal for service.

After the summary questions in each chapter, the guide offers the experience of one local planning group, the Timiskaming Detoxification Planning Committee. The Timiskaming planners have worked since 1991 to create withdrawal management services in their

community. They volunteered to test our planning framework. When they were approached by our committee, they had already completed a needs assessment, had formed a group of community representatives and were beginning to plan a withdrawal management service. The collaboration benefitted us both. The experience of Timiskaming planners provides other groups with one example of how the framework can be developed for a specific community. This section will be updated to include different experiences as other groups work through the planning process.

Withdrawal management services are a vital part of the addiction treatment system and are currently needed by the majority of planning districts in Ontario. They can play an increasing role in Ontario's treatment system by adding service awareness, withdrawal management assessment, and planning for continuing treatment activities to service plans.

Although the social setting detox centre has become the standard method of delivering detoxification services to Ontario citizens, it was designed for an urban setting. This urban model has drawn attention away from exploring alternative services that might be more suitable for non-urban areas of the province. Settings other than detox centres are used to provide detoxification services in non-urban Ontario, and these alternatives should be considered by service planners.

Service plans are best developed by community planning groups. Community planning ensures that services will respond to community needs and the needs of individual clients. Also, we are promoting service delivery measures that are more effective and less expensive in the long run, and local groups can best implement these proactive measures.

Ontario's detox centres serve many people who need help to manage withdrawal. The objectives of detox centres and their target population have evolved since the first centre was established in 1968. Originally, they were created to provide the "chronic drunkenness offender" with a non-judgmental and safe alternative to jail. Subsequently, it was determined that detox centres were cost-effective in large urban centres. Recently, each detox centre has set its own objectives, and these can differ from centre to centre. In 1992, these objectives were reviewed by the Community Mental Health Branch of the Ontario Ministry of Health, resulting in an expanded mandate.

The detox centre target population has been the subject of review in studies and government reports. The Community Mental Health Branch of the Ontario Ministry of Health defined an expanded target population for detox centres, which now includes drug users. Statistics collected by detox centres for the Ministry of Health characterize the population being served by gender, age and referral source. However, there is a need for more detailed data about Ontario's detox centre clients, and a need to account for those who are not reaching detox

centres and may be receiving assistance from other sources. Exploring alternative ways of delivering service requires that planners define the target population and ensure that these people have access to the service.

In Ontario, there has been no effort to develop a general structure for planning withdrawal management services. In such a structure, detox centres, as well as other ways of managing withdrawal, would all have a role. This guide provides a framework for planning that community groups can use to explore different ways of delivering service.

Getting Started

This chapter reviews considerations for forming a community planning group and identifying community needs and resources.

The development of this framework will require a local planning group of professionals, volunteers and consumers. A broadly representative group has three major benefits. First, when the planning group includes referral sources for the service, appropriate referrals will increase. Second, the planning group will become a network that links caregivers and volunteers in the community, thereby increasing service responsiveness and reducing the cost to the system of delivering care. Finally, by including local addiction treatment professionals and consumers in the group, planners can take a systematic approach to delivering addiction services in their community.

Planners can identify both the quality and quantity of need in their community, and can use as resources in this process the District Health Councils (DHC's) of Ontario and the Addiction Research Foundation (ARF). The formula of ARF scientist Brian Rush is a guide that can be adjusted to reflect community realities and the service being planned. This formula shows that six per cent of those who need treatment will need detoxification. Planners can also assess the needs of people who are not covered by Rush's formula, such as people under the age of 15 and people who need help because of drug use. If an increase in demand is expected, it should be included in the needs assessment. Also, needs assessments can be adjusted to accommodate early intervention strategies and multi-stressed populations.

When identifying community resources, planners can include addiction services, residential health facilities, outpatient settings in health care and social services, and the volunteer network.

The Planning Framework

Not all people who have problems with alcohol or drugs require detoxification. As a working definition for planning groups, we have identified four types of people who could be

considered candidates for withdrawal management services. We include people who, *because of alcohol and/or drug use,* are: disruptive or a danger, entering health care facilities, preparing for continuing treatment, or unable to withdraw alone.

To guide planners, we selected the following outcome objectives for withdrawal management services: to reduce the use of non-detoxification services for the purpose of withdrawal; to reduce the incidence of disruption caused by substance abuse; to reduce the per person cost of withdrawal management services. We also defined implementation objectives, "outputs" and short-term outcome objectives, and summarize the service framework in a logic model to assist planning and evaluation. It includes the four components described below.

1. Service Awareness

Recent publications describe activities designed to promote an awareness and increase use of services, and are based on social marketing techniques. A service awareness exercise can also begin to reduce fears and misconceptions about the service.

As a first step, a service awareness campaign will identify and reach a broad range of local referral sources. The campaign will also develop a series of messages that build upon the knowledge level of each referral source. Customized service awareness activities that use existing channels for education will encourage the participation of referral sources and reduce costs.

A toll-free telephone number to reach withdrawal management staff can encourage referrals to the service. Planners can also consider ways of "finding referrals."

2. Assessment

Assessments anticipate care requirements and reduce complications during withdrawal. They allow caregivers to structure a care plan around a client's needs and resources, resulting in strategies that are minimally intrusive and cost-effective.

As a first step, staff will identify people who are not appropriate for the service. People who require urgent medical or psychiatric attention are not candidates for withdrawal management services until the emergency has been addressed by the medical community. If a client has a history of seizures or *delirium tremens* in previous withdrawal attempts, he or she should be referred to an inpatient medical facility for managing withdrawal. People with severe concurrent medical disorders (physical or psychiatric) should probably be referred to a medical facility for inpatient management of withdrawal.

We support the development of a standard technique for assessing and monitoring the client during withdrawal. The benefits of a standard technique include: increased consistency; reduced costs; increased confidence in small urban, rural and remote communities where staff work in isolation; and improved training of a mix of health and allied health professionals, volunteers and specialized addiction staff.

We tried to find a suitable standard instrument for use in rural and remote areas and small urban centres, and identified two instruments for further study. The CIWA-Ar scale is used to quantify withdrawal symptom severity and to monitor response to treatment. The SADQ has been used in a variety of studies to assess alcohol dependence, and is currently used in the delivery of home detox services. These instruments need to be used in the range of settings proposed in the planning guide before we can recommend them. Questions remain about how the instruments should be used in relation to the staff, settings and procedures we outline.

In the absence of a standard protocol, we looked to other services for guidance. The Exeter Home Detox model, developed in Exeter, England, uses physical and psychosocial indicators to determine suitability for home detox. The assessment strategy is to establish need, to assess risks and to gain written consent. The Maudsley Alcohol Treatment Service of London, England, offers a range of services and uses a comprehensive assessment to match the client with appropriate withdrawal management care.

We conclude that staff will select service options based on the best information available. Therefore, assessment procedures should also include a guide for adjusting the plan to meet service standards. Each adjustment can be documented and reviewed as part of service evaluation.

3. Withdrawal management

Withdrawal is a physical and psychosocial process. When managing withdrawal, staff arrange the psychological and social influences on a client's life in a way that will support the physical process — the safe elimination of toxic substances from the body. Their job is finished when the client's health has been restored to some extent, and the client is ready for continuing treatment.

Appropriate places for withdrawal management are various, depending upon the client's needs and resources. The duration of care will vary from client to client and setting to setting, but an average of five days could be used in planning.

Transportation is an important aspect of providing service and can be viewed in two ways: transporting the service to the client and transporting the client to the service. We reviewed the efforts of one local planning group to establish a system for transporting clients to the service, as well as the effect these efforts had on policy-makers.

Monitoring, which ends when withdrawal is completed, is another key phase of withdrawal management. It is the ongoing evaluation of the client's physical and psychosocial condition. Monitoring allows staff and support persons to respond to changes in the client's needs and resources after the assessment. Staff need to be prepared for medical emergencies and to have procedures in place for initiating emergency medical care. Trained staff, volunteers, and/or an informed client support system can monitor clients.

Withdrawal management services can be delivered in a range of settings when provisions are made for appropriate physical and psychosocial support. For example, medical management can be provided in a variety of settings, as long as a physician's assessment has been obtained and someone is available to supervise the client's prescription. Medically managed home detoxification has been implemented in England, Scotland and Australia.

Planning groups can consider the seven service delivery options described in the guide in terms of what is available and needed in their community. By implementing a range of options, the service will be able to respond to the unique needs and resources of individuals seeking assistance. We describe seven options for service delivery and provide guidelines which can be explored during service planning. A menu system attempts to define suitable service options for all levels of withdrawal symptom severity, including:

Option One	At home, with family or friends providing ongoing monitoring;
Option Two	At home, with a volunteer providing 24-hour monitoring during physical withdrawal;
Option Three	At home, with periodic medical supervision, with or without volunteer monitoring;
Option Four	At a friend's or volunteer's home, with or without periodic medical supervision;
Option Five	Outpatient/day withdrawal management to which clients travel;
Option Six	Outpatient withdrawal management which travels to clients;
Option Seven	Residential withdrawal management in a social or medical setting.

Options One through Four use the home environment to deliver withdrawal management services. The home is either the client's, a friend's or a volunteer's. Medical management is delivered through the co-operation of a family doctor and a community nurse. Monitoring is provided based on the client's physical and psychosocial needs.

Volunteers, when used appropriately, make a cost-effective contribution to service delivery. When client homes cannot provide a supportive environment, volunteer homes could be used as an alternative to residential care.

Options Five and Six describe a range of outpatient service to which the client travels or which travel to clients. Outpatient services can be provided in a variety of ways. We have identified in the literature several models that can be modified for use in delivering withdrawal management services in small communities. For example, a mobile withdrawal management service can be modelled upon a mobile treatment unit developed in Saskatchewan. As a co-ordinating team, the mobile unit would use the community's resources to offer options for managing withdrawal. A mobile unit provides outreach to remote areas that do not have access to service.

Up to 20 per cent of withdrawal management clients may need care in a residential setting, such as a detox centre, hospital or addiction treatment facility. The use of designated beds in existing residential facilities will help to reduce the costs of implementing and delivering the service, but will require a strong local commitment to planning.

4. Planning for Continuing Treatment

By assisting clients to make contact with continuing treatment and community services, staff can: build upon established community links, encourage client recovery, and discourage relapse. Detox centre statistics show that there are problems associated with planning for continuing treatment. Ensuring access to continuing treatment options will challenge community planning groups in a variety of ways.

Withdrawal management services create clients for continuing treatment; it is therefore important to have continuing treatment options available. Planners need to compile a list of continuing treatment options in the early planning stages; this list could become a local directory of services and useful contacts.

Withdrawal management staff can provide clients with information about continuing treatment options so that they can make informed choices. In order to identify options for continuing treatment, staff will thoroughly assess the long-term needs and

resources of clients, preferably with the involvement of clients and their support persons.

Taking the Final Steps

In this chapter, we outline a basic structure for a funding proposal for withdrawal management services and some key concepts in evaluation. At the least, evaluation plans include the setting of outcome objectives and the monitoring of outcomes. A management information system can help with evaluation by monitoring service delivery and documenting the client's progress. Staff, volunteers and clients should be involved in making the service more effective and efficient.

Challenges for the Future

A Guide for Planning Withdrawal Management Services in Rural and Remote Areas and Small Urban Centres of Ontario brings together information and planning tools to support the efforts of community planning groups, the Ontario Ministry of Health, the Addiction Research Foundation (ARF) and the Ontario Detox Directors' Association (ODDA). The guide closes with a challenge to each of these groups.

Community planning groups are challenged to develop responsive, comprehensive, cost-effective service plans that use a variety of settings and methods for managing withdrawal. The Ontario Ministry of Health is challenged to support community planning groups by soliciting proposals through the DHC's for alternative methods of delivering withdrawal management. We also hope that the Ministry will support the involvement of the DHC's in local planning initiatives for innovative withdrawal management services, from needs assessments, to the review of local systems issues for delivering addiction services. The ARF is challenged to develop and test withdrawal assessment instruments that could be used by community planners, and to assist in the planning and evaluation of innovative withdrawal management services that are developed using this guide. The ODDA is challenged to take a leadership role in the exchange of information about withdrawal management services.